

As long as the grass grows and the rivers flow...

Direct Service Tribes
First Annual Meeting
Pointe South Mountain Resort - Phoenix, AZ

FINAL REPORT

June 1-4, 2004
Phoenix, Arizona






Table of Contents

Letter from Direct Service Tribes Planning Committee Co-Chair	5
Conference Letter from Dr. Grim, Director, Indian Health Service	7
Final Conference Agenda	11
Conference Minutes	19
Area Caucus Information and Area Caucus Reports	
Area Caucus Information	47
Aberdeen Area	51
Albuquerque Area	57
Bemidji Area	65
Billings Area	69
Navajo Area	71
Oklahoma Area	79
Phoenix Area	83
Portland Area	89
Tucson Area	93
Evaluations and Comments	95
Conference Attendees List	103
Sponsors List	115





As long as the grass grows and the rivers flow...

Direct Service Tribes
First Annual Meeting
Pointe South Mountain Resort - Phoenix, AZ

Dear Mitakuye Oyasin:

It is with great pleasure that the Planning Committee of the Direct Service Tribes (DST) Advisory Committee presents the results of our first Annual Direct Service Tribes Conference whose theme is ***"As Long As The Grass Grows and the Rivers Flow."*** This theme was chosen to represent the foundation of the Direct Service Tribes' close connection to the Indian Health Service and reaffirms the belief that treaties insure healthcare will be delivered effectively. Treaties are considered to be the sacred word of our ancestors, their hopes and belief that the future of their children and grandchildren would be assured in their exchange of millions of acres of valuable land to the federal government. Indian people honor and hold those words as sacred trust to protect and continue the struggle to insure healthy individuals, families and Tribes.

The DST Planning Committee, over a period of months worked hard to deliver a unique and successful conference. The conference was designed to be a working conference, involving the attendees in addressing the problems and finding solutions focusing on Area specific issues. We attempted to honor tribally owned enterprises, hotels and conference centers, however due to budget and time constraints we were unable to secure a tribally owned facility that would meet our needs. We contacted some of the best minds with keen analysis of the issues to speak. We were not disappointed.

The evaluations from the conference give us a clear picture of attendee opinion and interest and provide feedback for us to plan a better conference next year. This conference was a great success and far exceeded our expectations in attendance numbers and conference outcomes. The conference generated a great deal of interest and speaks to the need for representation and advocacy for the Direct Service Tribes. We honor Dr. Grim's commitment to Treaties and his support. The DST Planning Committee thanks each participant for their interest and support for the First ever Direct Service Tribes Conference. The work has been completed for DST formation as a formal organization further lends support for another strong voice advocating for better health care for American Indians.

Sincerely,



Carole Anne Heart
DST Planning Committee Chair





OS



ACF



AOA

CDC

CMS

FDA

HRSA



SAMHSA



2004 Direct Service Tribes

First Annual Meeting

“As long as the grass grows and the rivers flow...”

June 1-4, 2004

Phoenix, Arizona

“Direct Services is a Self-Determination Option”

by

Charles W. Grim, D.D.S., M.H.S.A.

Assistant Surgeon General

Director, Indian Health Service

June 2, 2004

It is an honor to be here with you today, on behalf of the Indian Health Service (IHS) and Health and Human Services (HHS), at this historic First Annual Meeting of the Direct Services Tribes. I want to thank Carole Anne Heart and Councilman Garland Brunoe for their leadership on the planning committee for this conference. This has been an effort primarily driven by Tribal representatives, with Indian Health Service staff facilitating and supporting your efforts. I commend you all for your strength and your commitment in ensuring that all Tribes' voices and positions are heard.

The foundation of the Indian Health Service is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures, and to honor and protect the inherent sovereign rights of Tribal Governments. The mission of the Indian Health Service, in partnership with American Indian and Alaska Native Tribes, is to raise their physical, mental, social and spiritual health to the highest possible level. This partnership provides options for Tribal Governments to help determine the manner in which the IHS mission is accomplished.

Tribes have a right to contract or compact for these health services under the Indian Self-Determination Act. An equal expression of Tribal Self-Determination is the right not to contract, and to have Indian Health Service provide these health services to your Tribal members.

The Secretary and the Deputy Secretary are committed to visiting and consulting with Tribes. They travel regularly into Indian country for the purpose of expanding access to HHS programs. The Secretary's "One Department" initiative, when it comes to Tribal

The text is the basis of Dr. Grim's oral remarks at the Direct Service Tribes Conference in Phoenix, AZ on June 2, 2004. It should be used with the understanding that some material may have been added or omitted during presentation.

issues, has resulted in many significant gains. Some of the more significant accomplishments of the past year include:

Improved Tribal Access to HHS Resources: Between FY 2001 and FY 2003 HHS resources that were provided to Tribes or expended for the benefit of Tribes increased \$3.9 billion in 2001 to \$4.4 billion in 2003. These gains came in both appropriated funding as well as increased Tribal access to non-earmarked funds and increases in discretionary set asides. This reflects an 11% increase in access to HHS funding for Tribes over a 2-year period.

Medicare Reform Act: The Secretary, the Administration, Tribal leaders, and IHS staff worked very hard to modernize Medicare so that American Indians and Alaska Natives would benefit. The President's leadership, Secretary Thompson's support, and Tribal advocacy ensured that the Act contained provisions that would benefit all Americans. One intent of this bipartisan agreement was to ensure that Indian health programs are included in future regulations, policies, and programs that will be developed from this legislation. Federal reimbursement of emergency health services furnished to undocumented aliens, the Temporary Drug Discount Card provision, and the Permanent Medicare Part D Drug Benefit beginning January 2006, are all responsive to Tribal legislative priorities identified for Centers for Medicare and Medicaid Services.

CMS Tribal Technical Advisory Group: In response to Tribal leader's comments at the regional Tribal consultation session supporting a C-M-S-T-T-A-G, HHS established the T-T-A-G requested by Tribal leaders. The first formal meeting was held on February 10, 2004 in Washington, D.C.

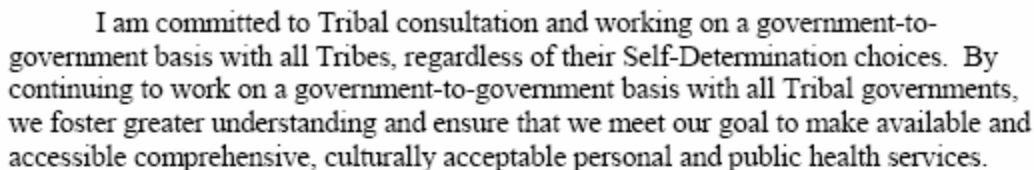
HHS Tribal/ State Relations Collaboration Project: HHS, the National Congress of American Indians and the American Public Human Services Association have entered into a collaborative project to work together on health and human services provided to Indian Tribes and Native organizations. This is in response to Tribal leader's comments at the regional Tribal consultation sessions requesting HHS to help bridge Tribal/state relations for HHS programs administered through states. HHS is forming a workgroup to focus on key areas of priorities identified by Tribes such as TANF, Child Welfare, and Information Systems.

HHS Restructuring: During regional consultation sessions, Tribes requested that IHS be exempted from the FTE reductions and the Human Resources consolidation associated with the HHS restructuring and consolidation efforts. In keeping with these recommendations IHS FTE targets for FY 2004 and 2005 have been revised to preclude reductions and the IHS HR function is not included in the HHS HR consolidation initiative.

Head Start Program: During the regional consultation sessions, Tribal leaders urged that the Head Start program not be moved to the Department of Education. In keeping with this recommendation the Head Start Program will remain in HHS.

HHS Revising Tribal Consultation Policy: In response to Tribal leader comments at the regional Tribal consultation sessions to improve Tribal consultation and inter-governmental relations, the Secretary is revising the existing HHS Tribal consultation policy and is involving Tribal leaders in this process. A workgroup is being formed to assist HHS in completing the revisions. Indian Health Service is working with Tribal leaders to revise our own Tribal consultation policy. This is an important Tribal initiative and I am committed to facilitating and completing this process over the next few months.

The text is the basis of Dr. Grim's oral remarks at the Direct Service Tribes Conference in Phoenix, AZ on June 2, 2004. It should be used with the understanding that some material may have been added or omitted during presentation.




One important issue on which I have sought input from Tribes is the restructuring of the IHS Headquarters. In April I presented my reorganization plan to the Secretary and gained his approval to move forward with implementation. The new structure will reflect current and emerging priorities of the Agency. The new structure will have three offices inside the Office of the Director and seven offices outside the Office of the Director. The three "interior" offices include the Office of Tribal Programs, the Office of Tribal Self-Governance, and the Office of Urban Indian Health. I have placed those offices that have direct contact with Tribes and Tribal organizations, and with urban Indian health, in the immediate Office of the Director so that I can better respond to important issues impacting the provision of services to Tribal governments and urban Indian programs. Implementation of the restructuring has begun and should be complete by the end of the fiscal year.

One of the ways we maximize our limited financial resources is to look for opportunities to build networks and partnerships wherever possible within HHS, with other Federal agencies, and also with private organizations. We are focusing many of these collaborations and partnerships in the area of health promotion and disease prevention. Examples of organizations with which we have existing partnerships include The National Congress of American Indians, the National Boys & Girls Clubs of America, the United National Indian Tribal Youth, the American Indian section of the Society for the Advancement of Chicanos and Native Americans into Science program, the CJ Foundation, and the NIKE Corporation.

We are collaborating with NIKE on the promotion of healthy lifestyles and healthy choices. The Memorandum of Understanding (MOU) is a voluntary collaboration between business and government that aims to dramatically increase the amount of health information available in American Indian and Alaska Native communities. The goal of the MOU is to help those communities gain a better understanding of the importance of exercise at any age, particularly for those individuals with diabetes. One of the outcomes was that NIKE conducted a 3-day training course for Tribal members to certify them as physical fitness coordinators. The trainers are now expected to implement fitness and exercise programs for

Page 3 of 4



their communities. NIKE and the IHS hope to conduct similar training programs for additional regions of the country.

Another beneficial partnership is one that focuses on the health needs of American Indian and Alaska Native veterans. The Department of Veterans Affairs and the Department of Health and Human Services established a Memorandum of Understanding to improve the access and quality of health care for our nation's American Indian and Alaska Native veterans. We have long had partnerships with the VA in the regions where we operate together, but this MOU is intended to take a national approach to helping out both the veteran community and the Indian community. By the end of this year, each Veterans Health Administration network and facility manager will have met with their IHS counterparts and local Tribal leaders to develop a comprehensive plan, describing how they intend to meet the needs of the American Indian and Alaska Native veterans living in that region. This partnership is going to make a difference in the lives of so many people who truly deserve our care and our thanks.

The most effective and efficient use of our critical resources and partnerships requires that we have the best possible health professional and support staff to deliver services. Over 70% of IHS hospitals and 25% of health centers are directly operated by IHS. However, there continues to be an increasing national shortage of health professionals. Within the Indian Health delivery system the need is growing as more staff members retire, as new facilities are constructed with their larger staffing needs, and as our patient population increases. Some current health professional vacancy rates stand at 11 percent for Physicians, 24 percent for Dental, 11 percent for Nursing, and 7 percent for Pharmacy.

The Secretary and the Deputy Secretary, and their staff, have frequently visited Indian Country and they know of our challenges and shortages. To aid the agency, last July the Secretary designated that at least 275 of the 1000 new Commissioned Corps officers recruited would be assigned to the Indian Health Service before the end of September 2004. The cost of additional staff will be offset in part by the reduction of contracted staff services. As a larger Commissioned Corps force is developed, the length of deployments will be shortened as well as their frequency. For extended deployments, those absences may be covered by the revitalization of the Inactive Reserve Corps, a part of Secretary Thompson's Commissioned Corps Transformation Initiative. Since the Secretary began the transformation initiative in August 2001 – the Inactive Reserve has provided over 2,000 work days of coverage for the Indian Health Service – demonstrating the effectiveness of the system.

I want to thank Tribal Leaders for your commitment and the many hours of time that you dedicate to consultation with the Department and the Agency on critical legislative and policy issues. This is an historic meeting that reinforces the foundation and the mission of the Indian Health Service, and makes clear that choosing to have health services directly provided by the IHS is an equal expression of Tribal Self-Determination. Your rights will continue to be honored and your voices will continue to be heard through Tribal consultation at all levels of government. The Secretary and I will continue to advocate for greater Tribal access to more programs within HHS.

I appreciate the opportunity to speak with you today and to partner with you in accomplishing the IHS mission of raising the health status of American Indians and Alaska Native people to the highest possible level. Your contributions to Indian health benefit many people beyond your own Tribes, and will continue beyond your own generation.

Thank you.


* * *

The text is the basis of Dr. Grim's oral remarks at the Direct Service Tribes Conference in Phoenix, AZ on June 2, 2004. It should be used with the understanding that some material may have been added or omitted during presentation.



Final Conference Agenda





As long as the grass grows and the rivers flow...

Direct Service Tribes
First Annual Meeting
Pointe South Mountain Resort - Phoenix, AZ

Tuesday, June 1, 2004

Registration

8:30AM – 5:30 PM

Pointe South Mountain Resort - Lower Lobby

Welcoming Reception

6:30 – 8:30 PM

Paseo Patio

Opening Prayer: Jerry Freddie
Chairman, Navajo Nation Health & Social Services Committee

Welcome Address: Dallas Massey Sr.
Chairman, White Mountain Apache Tribe

Speakers: John R. Lewis, Executive Director, Inter-Tribal Council of Arizona
Don J. Davis, M.P.H., Area Director, Phoenix Area IHS
Kathy Kitcheyan, Chairwoman, San Carlos Apache Tribe

Conference Overview:
Carole Anne Heart, Co-Chair, Direct Service Tribes Planning Committee
Reuben Howard, Executive Director, Pascua Yaqui Tribe Health Department

Musical Entertainment: That D.A.M. Band featuring Clan Destine



Wednesday, June 2, 2004

Healthy Walk/Water Aerobics
Fitness Center and PSM Trails

6:30 AM

General Assembly
Lantana and Mohave Ballrooms

8:30AM

Call to Order: Carole Anne Heart and Garland Brunoe
Co-Chairs, Direct Service Tribes Conference Planning Committee

Posting of Colors: American Indian Veteran's Memorial Organization Color Guard

Flag Song: Kathy Arviso, Navajo

Opening Prayer: Jerry Freddie
Chairman, Navajo Nation Health & Social Services Committee

Keynote: Charles W. Grim, DDS, MHSA
Director, Indian Health Service **9:00 AM**

Remarks: **9:20 AM**
Don Kashevaroff, Chairman, Tribal Self-Governance Advisory Committee
DJ Lott, President, National Council on Urban Indian Health

Break **Sponsored by the Pascua Yaqui Tribe** **10:20 AM**

Area Tribal Leader Comments **10:35 AM**

Health Priorities of your DST w. the IHS

Nora McDowell, Chairperson, Fort Mojave Tribe
Frank Dayish, Vice-President, Navajo Nation
George Howell, President, Pawnee Nation of Oklahoma
Roland Johnson, Governor, Pueblo of Laguna
George King, Interim Chairman, Red Lake Tribal Council
Vivian Juan-Saunders, Chairperson, Tohono O'odham Nation
John Blackhawk, Chairman, Winnebago Tribe
Portland Area Tribal Leader


Luncheon **12:00 PM**

Pointe South Mountain Resort

Entertainment: Drew Lacapa, Comedian

General Assembly **1:00 PM**
Lantana and Mohave Ballrooms

Panel Discussion I: Federal Perspectives on the Budget Process
Facilitator: Amadeo Shije, Albuquerque Area



Overview of Process: Rosetta Tracy, Budget Analyst, Budget Formulation and Presentation, DFM/IHS
Department Process: Nick Burbank, Office of the Assistant Secretary for Budget, Technology and Finance
OMB Process: Charles Montgomery, Office of Management and Budget
Appropriations Committee: Danna Jackson, Legislative Assistant for the Office of Senator Tim Johnson (SD), Appropriations
Agency and Hill Budgeteer: Deborah Broken Rope, Holland and Knight Law Offices
Segue to Tribal Perspectives: Cindy Darcy, Legislative Director, Dorsey & Whitney

Panel Discussion I (continued): Tribal Perspectives

2:30 PM

Facilitator: Evelyn Acothley, Navajo Area

Overview, History and Change: Everett R. Rhoades, MD, Advisor, Southwest Oklahoma Inter-Tribal Board
Milburn H. Roach, Advisor, Southwest Oklahoma Inter-Tribal Health Board

Budget Training, Advice and Analysis:

Rachel Joseph, Chairperson, Lone Pine Paiute-Shoshone Tribe
Alida Montiel, Health Systems Analyst, Inter Tribal Council of Arizona
Ed Fox, Executive Director, Northwest Portland Area Indian Health Board
William E. Jones, Sr., Budget Formulation Committee, Self-Governance Tribes
Jerry Freddie, Chairman, Navajo Nation Health & Social Services Committee

Break Sponsored by the Pascua Yaqui Tribe

3:45 PM

Adjourn

5:15 PM

Area Caucuses

5:30 PM

Reception for Regional Directors

7:00 PM

Pointe South Mountain Resort

Panel Discussion II: Regional Director's Panel: Servicing DST's

Facilitator: Mathew Tomaskin, Portland Area

Brian Cresta, HHS Regional Director, Region I
Linda Penn, HHS Regional Director, Region IV
Joe Nunez, HHS Regional Director, Region XIII
Emory Lee, HHS Executive Officer, Region IX (Representing Calise Munoz, HHS Regional Director)



Thursday, June 3

Healthy Walk/Water Aerobics
Fitness Center and PSM Trails

6:30 AM

General Assembly
Lantana and Mohave Ballrooms

8:30AM

Call to Order: Carole Anne Heart and Garland Brunoe
Co-chairs, Direct Service Tribes Conference Planning Committee

Opening Prayer: Roland Johnson, Governor, Pueblo of Laguna

Welcome Address: Janet Napolitano, Governor, Arizona – written remarks
read by Carmelita Sanchez, Lt. Governor, Zuni Tribe

Keynotes: Jennifer Farley, Deputy Associate Director **9:00 AM**
Office of Intergovernmental Affairs, Office of the White House

Congressional Video Announcements **9:30AM**
Senator Inouye (D-HI)
Senator Tim Johnson (D-SD)
Representative Rick Renzi (R-AZ)
Senator Tom Daschle (D-SD) -written remarks read by Carole Anne Heart

Remarks: Tex Hall, President, National Congress of American Indians


Break **10:15 AM**

Panel Discussion III: Upholding the Federal Responsibility **10:45 AM**
Facilitator: Reuben Howard, Tucson Area
Raymond Etcitty, Navajo Nation Chief Legislative Counsel
June Tracy, Legislative Analyst, Congressional & Legislative Affairs Staff
Michael Hughes, Consultant on Indian Affairs

Remarks: **Revised Health Care Facilities Construction Priority System** **11:45 AM**
Bruce Chelikowsky, Acting Director, Office of Environmental Health & Engineering

Lunch **(On Your Own)** **12:00 PM**

Panel Discussion IV: Building Opportunities, Networks and Partnerships **1:00 PM**
“Expanding the Relationship”
Facilitator: Hilda Moss, Billings Area
John Hammerlind, Centers for Medicare and Medicaid Services
Russell Alger, Chief Executive Officer, Warm Springs Service Unit



Kathy Annette, MD, Area Director, Bemidji Area IHS
Wesley Clark, Director, Center for Substance Abuse Treatment (CSAT), Substance
Abuse and Mental Health Services Administration
Barbara Sabol, W.K. Kellogg Foundation

Panel Discussion V: Indian Health Appropriations: 2:30 PM
Entitlement vs. Discretionary

Facilitator: George Howell, Oklahoma Area
Senator Albert Hale, AZ State Legislator
Roland Johnson, Governor, Laguna Pueblo


Break 3:45 PM

Panel Discussion VI: Documenting the Need - Information as Power 4:00 PM

Facilitator: Jody Abe, Phoenix Area
Keith Longie, Chief Information Officer, IHS
Cliff Wiggins, Operational Research Analyst, Office of the Director, IHS
Ralph T. Bryan, Senior Tribal Liaison for Science and Public Health, Office of Minority
Health, Office of the Director, Centers for Disease Control
Jenny Jenkins, Chief Executive Officer, Cass Lake Service Unit

Adjourn 5:15 PM

Area Caucus 5:30 PM



Friday, June 4

Healthy Walk/Water Aerobics

6:30 AM

Fitness Center and PSM Trails

General Assembly

8:00AM

Lantana and Mohave Ballrooms

Call to Order:

Carole Anne Heart and Garland Brunoe
Co-chairs, Direct Service Tribes Conference Planning Committee

Opening Prayer:

Nelson Wallulatum

Area Caucus Representative Presentations:

8:30 AM

Defining Direct Service Tribes

The Future of Direct Service Tribes

Break

9:45 AM

Area Representative Presentations:

10:00 AM

Health Priorities of Direct Service Tribes

Next year's conference Goals, Themes and Tracks

Conference Summary: Carole Anne Heart and Garland Brunoe

11:15 AM

Closing Remarks: Dr. Charles Grim, Director, IHS

11:30 AM

Closing Prayer: George Howell, President, Pawnee Nation of Oklahoma

Closing Song: Gary Elthie, Navajo Nation

Retiring of Colors: American Indian Veteran's Memorial Organization Color Guard

Adjourn – SAFE JOURNEY HOME

12:30 PM



Conference Minutes





DIRECT SERVICE TRIBES

FIRST ANNUAL MEETING POINTE SOUTH MOUNTAIN RESORT – PHOENIX, AZ.

Meeting Minutes

Tuesday, June 1, 2004



Carole Anne Heart introduced herself and explained situation of Direct Service Tribes. She said Direct Service Tribes are comprised of nine areas. They are primarily tribes located in the Midwest. She stated all of the tribes in those areas. She introduced Dallas Massey, Sr.


Dallas Massey, Sr. welcomed meeting participants. He said in the next three days participants will be given vital information about the bureaucratic system involved in the healthcare delivery system. He said the theme of the conference, “As long as the grass grows and the rivers flow”, fits with historical treaty relationship between tribes and federal government. Because of treaty obligation, it is difficult for tribes to see that IHS doesn’t have the resources to meet the needs of tribal people. He said that IHS has come to mean emergency health, etc. Technology has become advanced but reservation residents are not able to access those technological advances. Indian health was always connected to nature to meet our needs. There was an element of compassion for one another, and survival was meant for one and all. There seems to be no remedy for the funding needs. There is need to improve relationship between medical staff and patients, bureaucratic relationships, data information services, etc. There are true budget negotiations possibilities under 638 laws. There is need to have true consultation between tribes and I H S. He said we must all work together to make change. Some of the projects his tribe, the White Mountain Apache’s is working on are:

- HRSA grant electronic health network. This will be a reservation wide case management system. He talked about how this program would allow tribes to have a truly comprehensive health plan. They can then use that data to get resources to address health disparities. There needs to be “Great healthcare leaders”.
- Working with governor’s office to work on Indian health issues in the state.
- Planning and expansion of new hospital.

This conference is good to address issues and to take practical things home to provide services that lead to good health.

The challenge to leaders has always been working together on timely and responsive basis. He feels this conference will allow participants to walk away with good information. He thanked the participants.

Carole Anne Heart introduced John R. Lewis.



John Lewis welcomed participants to Arizona. He said each of our tribes are doing good things and we need to share the information, be it the local community, national, etc. It is important for the well-being of tribal members that we share.

Carole Anne Heart introduced Don Davis.

Don Davis welcomed participants to the valley of the sun. He recognized conference sponsors. He gave history of change that has taken place of Native American people in healthcare. He said healthcare is very important to the quality of life that we have. People live longer, babies survive longer, and more survive childbirth. There have been great successes. Many people have a best practice at home but have not shared them. He told story of visiting Winnebago hospital and seeing a best practice in evidence. When we talk about the future, it is no longer that there are only a few Native Americans in the room. We can take some credit for that happening. He hopes we will share things in a good way this week.

Carole Anne Heart gave conference overview. She introduced the D.A.M. Band featuring Clan Destine.

Wednesday, June 2, 2004

Most of the day's minutes were not recorded due to technical difficulties.

Deborah Broken Rope said she knows that many administrators have to worry about tribal program needs but also those on national level. Executive branch sets the budget. She spoke about the separation of powers in Congress. Congress can only have indirect role in budget formulation. Agencies themselves have a lot of authority in determining set asides, etc. Also because of strong executive role you will always be concerned with larger federal picture regarding budget and discretionary spending. She said the bottom line is that there are three areas for funding priorities OMB uses.

- 1) Historical funding
- 2) New authorizations
- 3) Special initiatives

She explained some terminology; authorizations vs. appropriations vs. budget process. In this Congress, budget resolution process broke down. She explained three-year budget process that OMB uses.

- 1) Current fiscal year spending, which gives you historical base for next budget formulation
- 2) Upcoming budget formulations
- 3) Sending off OMB packet

She spoke about OMB justifications. They are time consuming but can work to a tribes benefit. Some of her suggestions:

- Use red paper to educate service unit people so that program people will understand potential earmarks, etc.
- Include data collections information
- Use marketing and Public Relations strategies to make needs known.



She thanked meeting participants.

Thursday, June 3, 2004

Carole Anne Heart introduced herself and Governor Roland Johnson.

Governor Roland Johnson gave the opening prayer in his native language.

Lieutenant Governor Sanchez of Zuni read welcoming address for Arizona Governor Janet Napolitano.

Carole Anne Heart introduced co-chair Garland Brunoe. She introduced Jennifer Farley from the White House.

Jennifer Farley thanked Carole Anne and Garland Brunoe for putting together the DST conference. She acknowledged Dr. Grim for being here. She said the President was proud that she could attend meeting on his behalf. The President supports self-determination. She said they understand once a tribe chooses self-determination then government must provide healthcare. She and Carole Anne were talking about possibly holding a sovereignty conference in September. She gave participants her contact information.


She explained government to government relationship and said this administration respects that and to insure tribal sovereignty continues, administration is committed to improving education, economic development, and better access to health and human services for American Indian and Alaskan Natives.

Administration is proposing to spend over \$11billion on Native American programs.

She outlined the various budgets for programs using \$11 billion. She was asked to give commencement speech at Northwest Indian College this year. She said they are also working to decrease Diabetes and improve Medicare designed to improve quality programs for American Indians. She said in July 3rd 2002, President signed an Executive Order on American Indian and Alaskan Native Education. She said president also understands the commitment that American Indians have given as far as military service to the country. She spoke of Laurie Piestewa and Code Talkers. She spoke about completion of National American Indian Museum in Washington, DC. She acknowledged the intergovernmental relationship between HHS and the White House.



She stressed that dialogue and communication between tribes and the White House is very important, especially as it relates to tribal consultation in the budget process. She said the President recognizes the health disparities that exist for tribes.



Carole Anne Heart thanked Jennifer. She spoke of the importance of the partnership between tribes and National Indian Education Association. She introduced taped address from Senator Daniel Inouye.

Senator Daniel Inouye (via tape) said he appreciates opportunity to speak to DST meeting participants.

He said he reviewed DST meeting agenda. He explained the treaty obligation that holds the US government to be committed to healthcare. He said self-governance compactors realize that Direct Service Tribes still receive a higher quality of healthcare. He said Indian healthcare professionals have not always been compensated as well as others her work in government healthcare delivery. She spoke of the scourges of teenage suicide, alcohol and drug abuse, etc. need to be addressed. He commended meeting participants for working hard to meet healthcare needs.

Carole Anne Heart introduced taped address from South Dakota Senator Tim Johnson.

Senator Tim Johnson (via tape) thanked Carole Anne, Dr. Grim, and Direct Service Tribal Chairmen for meeting here.


He spoke about treaties role in establishing government-to-government relationship between tribes and US government. He spoke about the fact that the Indian Health Service is woefully under funded. He was especially discouraged by recent report from the United States Civil Rights Commission that IHS makes up a smaller percentage of DHHS discretionary budget today than they did five years ago. He said IHS has done their best to meet the needs with only half the funding they need. He said Senator Tom Daschle wants to double the IHS budget. He will join Senator Daschle in the fight to get the IHS budget increased.

He spoke of West Nile funds that will be made available to help tribes through the CDC. He said we need to continue to remind agencies like CDC that tribes exist and need to be supported. He thanked participants.

Carole Anne Heart introduced taped address from Arizona Senator Rick Renzi.

Senator Rick Renzi (via tape) apologized for not attending this historic event. He is impressed by DST mission and he is honored that he represents Native Americans in his district. He realizes that healthcare needs to be improved for Native Americans. He loves Native American values and traditional way of life. He said he has learned a lot from visiting Native American communities in Arizona. He said funding of IHS needs to be increased and he will support the increase. He spoke about situations in regards to lack of funding for education in Indian Country. He pledges to help the greatest of those in need, the first people of our land. He thanked participants for their time.

Carole Anne Heart said we have powerful advocates in Congress. She read a written statement from Senator Tom Daschle. In it, Senator Tom Daschle spoke about treaty obligations that are being ignored. He said Native Americans get less in federal spending than other smaller groups.




He said this is a national disgrace. He said “life or limb” is not a figure of speech. It is an IHS mandate due to the budget shortfall. He gave example of Indian woman in South Dakota who because of budget shortfall had cancer that went undetected until it was too late. He spoke about rationing of healthcare in Indian Country and “anorexic budget” of IHS. He said it is morally unacceptable to allow this to continue. He spoke about how Congress can find money for other things other than Indian items. He is working to get reports on discrepancies so that healthcare can be documented and that others will see the health disparities. He urged people to tell Congress about the situations they encounter because of IHS budget shortfall. He spoke of other initiatives he is working on. He thanked participants for their dedication.

Carole Anne Heart introduced Chairman Tex Hall.

Tex Hall thanked participants. He said he was really pleased to hear all the congressmen say they support us. We need more champions on the Hill. We need to encourage those speaking on tribe’s behalf to honor trust responsibilities. There needs to be a strategic Public Relations strategy.

Nationally, tribal organizations need to work together. Clearly, “Who is the next champion?” depending on who gets elected. We need to have a Plan B to get needs addressed. We cannot leave it to chance to select someone to speak on Indians behalf. We need to be strategic. Senator Inouye has been a terrific champion. He spoke about meeting with Senator Inouye. He said the respectable Senator Inouye voice is bi-partisan. He doesn’t get into the political fights. He reiterated the need to find the champions in congress. He is also concerned that there is a Public Relations issue. There are huge misconceptions about Indians. We need a strategy to turn that around. He used Indian Gaming as an example. The perception that all 562 tribes have large gaming revenues is untrue. Huge majority of tribes fall into category of unmet needs. Also majority of tribes have treaties behind them. He spoke about a conversation he had with Kansas Senator Brownback. He talked about mass hanging of Dakota Warriors in Minnesota. He asked what happened to our leaders? He said the strongest ones were killed to get rid of Indians because of gold, manifest destiny, etc. He said our own parents were oppressed and their way of life taken away. He said many of us say this country put worst holocaust in history of world on Indian people. There was also the biggest land grab in history from 1887 to reorganization act. He said while Indians were being educated they were losing land on force fee patents. He spoke about Apology Resolution. He said we must get behind resolution. Until we do, there will be anger in Indian Country. We must get on base before the homerun and unite behind the Apology resolution. When museum opens this fall we will recognize ancestors for their sacrifice. Regarding President Bush, he said in a speech, “America upholds its Treaties”. He agrees. He closed by saying regarding appropriations he is concerned that we are not getting any increases and our populations are growing. We need a strategic message to appropriators. He would like to see an initiative to get a message to Congress that we need that funding increase. He spoke about cancer increase on his reservation. If you have the funding, you can fight diseases like cancer adequately. We must be specific





and strategic in our thinking. We are losing the war in areas like cancer and diabetes. The election could make all the difference in the world for our people. Finally, regarding reauthorization, he feels we need to put the pressure on as far as reauthorization. We need to answer whom, what and how. People at home are depending on this legislation to literally survive. We must let Congress and the White House know that need signing of Indian Healthcare Reauthorization Act. He is confident that if we speak in a unified voice we can make a difference.

Carole Anne Heart called for a break.


BREAK

Reuben Howard introduced himself and made announcements. Explained agenda changes. He said it is his pleasure to facilitate Panel Discussion # 3: Upholding Federal Responsibility. He introduced panel members.

Raymond Etcitty gave his formal introduction. He said with regard to self-determination, we must remember this policy was developed over many eras, since Columbus' time on. He said our obligation is to educate people on self-determination. The federal government has many flaws in federal policy. He said Richard Nixon called for an end to end of determination era and called for self-determination. Congress has since then supported self-determination. Another facet of self-determination is economic development. Since the 1970's Congress has passed several laws to benefit self-determination like 638 contracts, Indian Gaming Regulatory Act, Indian Self Determination Act, etc. He spoke about the treaty government of the Navajo Nation. It is said that the Navajo Tribal government may be one of the most elaborate of tribes. He spoke about the structure of the Navajo Tribe. The Navajo Nation does not have enough funding, like other tribes. We need to find ways, through our industries, etc., to supplement funds to improve infrastructure, etc. Through economic development, we can support the lives of our tribal members, residents and visitors. He thanked the participants.

Reuben Howard introduced June Tracy.

June Tracy said she is representing Michael Mahsetky. Thanked participants for opportunity to make presentation. She said meeting participants have received critical history and perspectives from Dr. Everett Rhoades, former Director of IHS the day before. She said that history is important to have to communicate on policy level with people on national and international level. It is important to know history because we can show why it is important for Indian tribes to be dealt with in a manner that is consistent with federal relationship. She referred to debate on Navajo Nation when she was growing up, regarding whether Navajo tribe should join other tribes and adopt a constitution. They chose to go the way they have because they felt sovereignty in remaining a Treaty tribe. She said the truth is we will always have responsibility of presenting history to people in charge of considering our priorities. We want to define, present, and explain our own histories so that they are not left to interpretation. So with regard to federal responsibility, and trying to define relationship with tribes, why is it that the commitment of federal government and Native Americans and the way we perceive ourselves always a question. She believes it is the spiritual, historical legacy we all carry



on from one degree to another. She said we have always been self-determination. It only became official with federal recognition in the 1970's. Choosing IHS to serve our communities is self-determination. To contract, to compact, etc., that is self-determination. Within that framework, there are certain things we need to have done, for example, the Indian Health Care Improvement Act. She explained that Indian Health Care Improvement Act is a result of tribal consultation and represents presentation of how we believe federal responsibility ought to be carried out. She briefly spoke about two other Bills.

- 1) S-1696. The Bill is a self-governance demonstration Bill for up to 50 additional tribes to contract with other departments in HHS. This will give tribes ability to look at key health services through the other departments.
- 2) S-2172. The Bill requires IHS and BIA to fund contract support costs.

She wished participants the best.

Reuben Howard introduced Michaels Hughes.

Michael Hughes said he was glad to be here and said this a conference that is long overdue. He said a lot of what has been addressed deals with the budget. We are currently in extremely difficult fiscal funding environment, regardless of who gets elected in November. He said there are three elements that make it difficult:

- 1) A War situation
- 2) A federal budget deficit.
- 3) A weak economy

Then within our Indian world, we have other complicating factors such as; perception that Indians are wealthy because of gaming; struggle with accountability and reporting for our programs; we've lost credibility on Capitol Hill because of a certain tribe who lost a lot of money by compacting in late 90's and had to go to BIA to bale them out, and another tribe who fought the government on their compact. So we need to repair that loss of credibility with accountability. The other thing is that we haven't had a coherent strategy. When Clinton was in office we had a false hope that Clinton would support our funds but he ended up cutting our budgets. That was a result that we had no strategy. When Bush was elected and came to office in 2000, tribes said we don't need to ask for money because he is not going to give us more and then, Bush made health a priority and Bush put major increase to places like N I H because they came to administration with long range strategy. So we missed out there.


So now we need to have a strategy to go to second Bush administration or Kerry administration with strategy.

So what should be elements of strategy?

- 1) Support initiatives and strategies of Indian Health Service
- 2) Show accountability using institutional program assessment rating tools

Thanked participants.

Reuben Howard opened up floor for audience questions.



Dennis Smith thanked DST organizers. He said he has been in political arena for 11 years. He sees a lot of frustration and concern. This is not a political issue. We should take a moment and think about forefathers. We might not even be here today if our forefathers talked about self-governance, etc. So we need to think of future generations. We have advanced a long way from several years ago when tribes used to threaten one another with lawsuits, etc. We need to stick together as tribes. We need to start taking control of our own destiny because if we don't no one will do it for us. He spoke about how important the Lord is in his life. He spoke about the importance of paying attention to the federal government.



Herman Shorty wanted to take opportunity to introduce some students from Youth Opportunity. He said we would be further along if we would have gotten exposed to some of these things earlier on. Shared a story about a conference he attended about a young lady who gave a presentation in front of Senator Inouye.

Reuben Howard gave announcements.


Unidentified Speaker, said we heard from one of senate staffer to negotiate with congress so, we should ask that NCAI should negotiate with Congress. He is suggesting we request to reduce Foreign Service budget.

Reuben Howard introduced Bruce Chelikowsky.

Bruce Chelikowsky asked audience to take a stretch, thanked DST organizers. This is first opportunity he has had to present the new priority system to tribal group. This is a draft methodology. He gave overview of system, why it was developed and what will be asked of tribes. He explained health facilities process. It is a two-part system. They plan to identify facilities with most need, via ranking relative to one another. Updated data will be necessary.

- 1) Phase One: Look at all facilities through Master Planning process. Review existing data to identify highest priority projects.
- 2) Phase Two: Take highest-ranking facilities from Phase One and validate data, then put on priority list for potential funding. Apply it initially and then apply as necessary depending on positive or negative funding.

Funding will be key for both phases. Data is incorporated into Master Plan including health statistics, Service delivery plans, etc. It also includes specific facility data, i.e., age, size, condition, etc. During course of development of this process we found additional criteria that need to be addressed, for example, barriers to service and looking at innovative approaches to providing healthcare. Congress has also look at alternative ways to provide healthcare.



We will analyze based on 5 criteria:

- 1) Deficiency in space
- 2) Health Status
- 3) Isolation-physical distance and barriers to service
- 4) Recommended facility size
- 5) Innovation

Each has a weight whose total score adds up to 100. The three categories are:

- 1) Inpatient
- 2) Ambulatory
- 3) Small facilities

We have added the small facilities category. Another category will add specialty centers. We need to align this with what currently exists but we want to be in a position to target the need in Indian Country.

He spoke about how they should align facilities to compete for funds. By categorizing, it gives IHS opportunity to target funding. Why prepare a revised priorities system? There has been some congressional language to do that. To make sure that the new system incorporates things and takes factors into consideration that will meet the needs in Indian Country. Indian Health Care Improvement Act also has language in it mandating a look at the facilities priority system. There are many good reasons to do this. We established a work group in 2001 to develop recommendations for prioritizing need, weight for each, strategies for coordinating funding programs, etc. They put it together in a report to let tribal leaders know the plan. What we do now is put together methodologies to make this work.

The benefits of new priority system are:

- We have responded to what Congress has asked of us
- Identify total needs for facilities and put a price tag on it
- We'll have a ranking so we have ability to know where funds will go
- Incorporates existing funding authorities into one system
- Gives Congress ability to see where they want to put funds
- Tells tribe where facilities sit on rank order list


So what is next? The group recently met and sent methodology out for consultation. We are asking tribal leaders to review documents and give comments. We intend to incorporate comments into priority system. Comments are due at the end of September.

Jim Cussen asked rationale for five years for re-evaluation of priority review.

Bruce Chelikowsky responded that the rationale is that they were looking at timeframe where data would still be reliable and valid and wouldn't require tribes and IHS to do extra work in shorter period, i.e. three year, etc.

Jim Cussen asked innovation of facilities designed in yester year...weighting criteria (inaudible)

Bruce Chelikowsky responded that the info is included in packets.



Jim Cussen asked if facility is rated high would that increase staff quarters?

Bruce Chelikowsky responded that most recently, if quarters are required with facility, they are included in project. The justification is for facility and quarters are part of facility needs, they will be incorporated into project.

***** **LUNCH** *****

Hilda Moss began Panel Discussion IV: Building Opportunities, Networks and Partnerships, “Expanding the Relationship”. She said anymore IHS couldn’t do the job alone. She acknowledged her tribe and her group from Billings Area tribes. She introduced panelists.


Wesley Clark said SAMSHA provides resources for treatment via mental health grants. Vision of SAMSHA is “A Life in the Community for Everyone.” He explained how they meet that vision. They build resilience and facilitate recovery. The 11 areas of their matrix are:

- 1) (inaudible)
- 2) Increasing substance abuse treatment capacity
- 3) Addressing issue of seclusion and restraint
- 4) Developing a strategic prevention framework for communities
- 5) Working with children and families
- 6) Transforming mental health system
- 7) Addressing issue of disaster readiness and response from a behavioral health point of view
- 8) Homelessness
- 9) Elderly
- 10) HIV AIDS and hepatitis
- 11) Criminal justice

He said that is a lot. And they know issue of substance abuse is important to American Indians and Alaskan Natives. He gave statistics of smoking, drinking and illicit drug use among American Indians and Alaskan Natives. They have a cross cutting principle they use to meet goals.

- Science and evidence based practices
- Collaborating with public and private partners
- Focusing on recovery and reducing stigmas
- Addressing areas of cultural competence and eliminating disparities
- Addressing community and faith based approaches
- Dealing with issues of sexual abuse, trauma and violence
- Financing and cost effectiveness
- Addressing rural and other settings like reservations
- Work force development

We have to work with wide range of individuals in order to prosecute change. The President has a \$100million initiative on Access To Recovery. Organizations can apply for this money by tomorrow. It’s a voucher program that allows individual to apply for a wide range of recovery services. He explained the various services. They offer technical assistance to states and tribes to facilitate application process. In 2003 and 2004



SAMHSA awarded \$23.4million in grants to Native people. They welcome any opportunity to help with applications. Another important resource is the One Sky Center, a grant to enhance communication. www.oneskycenter.org.

Thanked participants.

Hilda Moss introduced John Hammerlind

John Hammerlind thanked IHS and National Indian Health Board for being invited to this meeting. He said he hopes it is the first of many. He described relationship between Centers for Medicare Services (CMS) and tribes. He said they work closely with IHS to improve support for tribes. He spoke about the importance of data initiatives between CMS, IHS, DHHS, and tribal organizations, etc. To that end, they have had conferences, etc.

With respect to the budget, CMS offers special funding for tribes through intergovernmental areas with IHS, etc. They also work with IHS through reimbursements, etc. They are trying to become a more transparent agency. With respect to consultation, they take their role very seriously to open up communication with tribes. They strive to open understanding of their very complicated programs. They try to gain a richer understanding of issues facing tribes. He gave example of when they dealt with issues and revised regulations regarding a tribe and improper Medicare recovery. To learn more about consultation strategy he asked participants to visit www.cms.hhs.gov.


CMS and IHS formed joint steering committee. Purpose of committee is to address areas of mutual concern.

- 1) Payment policy for Medicare and Medicaid
- 2) Program operations
- 3) Research and data needs
- 4) Legislative matters

He is impressed with mission and direction of the steering committee. There has always been a relationship between CMS and IHS, but this group helps even more. He explained the new group TTAG (Tribal Technical Advisory Group). They were formed recently to enhance the federal obligation and government-to-government relationship between tribes and federal government. They are currently working on outreach regarding Medicare drug card, etc. They are working on culturally appropriate information regarding drug card. He explained how CMS is organized.

Hilda Moss introduced Russell Alger.

Russell Alger appreciates this historic meeting. He said he wanted to share some success stories. He said we hear a lot about how budget deficits affect our programs. This is true, and it doesn't look like it will get any better. He explained how Warm Springs got their new clinic. They had some tough years when their budget went down, they have relied more and more on collections to staff clinic. They decided to focus on what could work. Some things that the staff has done to improve services are:

- 
- Diabetes money: They built a partnership between tribe and IHS to utilize money, some for “pre-diabetes”.
 - Physical Therapy: They cooperated with tribe and pooled money to fund a P.T. and equipment
 - Dialysis Center: With prevention effort they were able to tackle pre-diabetes effort
 - Domestic Violence program
 - Elder outreach program to visit with elders where they live.
 - Orthodontist was funded by a cooperation to put him through school
 - Electronic health record system
 - Special FDA sponsored chloral hexadine study Tooth decay with kids.
 - Coordinated with tribe for MCH program to identify high-risk moms.
 - Emergency Medical Services: They support education for paramedics, etc.
 - CHS program: Drug costs are kept down because of their unique program

He said his staff loves to come to work to make programs better. He said there are a lot of exciting opportunities out there.

Hilda Moss introduced Kathy Annette.

Kathy Annette said she is delighted to be here. She introduced her Bemidji area staff. She spoke about how she got her start and how all of her people pulled together in first five years to distribute dollars, etc. The approach they take in Bemidji is that all the area tribes are partners. They don't have separate meetings in the area. They all come together at the same time. She said the strongest partners in her area are the tribes. They develop a plan and they all buy into it. She spoke about situations they face because they have Direct Service and Contract tribes in the Bemidji Area. Another partnership in Bemidji is the tribes to tribes via forming consortiums to access resources, etc. Another party that impacts them is the states they live in. State regulations, etc. affect tribes. She spoke about Medicare regs in the state, and how they have had to tackle those issues by uniting. They met with the State and the State agreed and allowed Medicare reimbursements for wherever patient lives. Also, sometimes tribes compete with state for dollars. Tribes asked State to make set-asides available. They now work with state on regular basis. The next partnership is Wisdom Steps. Elders meet with state to talk about exercise, pharmaceuticals, etc. She said it is important to learn to access foundation money. She acknowledged Aberdeen Area for sponsoring earlier conferences. She believes there is sleeping giant in Indian Country, and that is the Direct Service Tribes, Self Governance tribes, etc. When they come together, they will be powerful.

Hilda Moss introduced Barbara Sabol.

Barbara Sabol said she had some information about how it is to create and sustain healthy communities. She gave history of W.K. Kellogg Foundation. She said the Kellogg Foundation doesn't just give money, they invest it. The set of values they have to use:

- The most vulnerable in our society has voice
- Diversity and inclusively
- Community capacity to solve problems

- 
- Collaboration and partnership is fundamental to make a bigger difference

Major investments in philanthropy go to three areas

- 1) Education
- 2) Health
- 3) Human Services

Most of Kellogg investments are in community based partnerships. That is because if you look at problems in healthcare, no one organization has all the answers. She spoke about how their guide is that “relationships are primary, all else is derivative”. Stories and identifying problem is important but most important is what you say about how you and partners will address the problem. What will you do? How will you measure what you do? Etc. Kellogg invests about \$200million a year. Private philanthropy at its best can never replace public responsibility, i.e., dollars from federal government. So it is important to look at policy changes to sustain funding. She spoke about how people can do that to change the system. In health they have three major strategies:

- 1) Access to care initiatives
- 2) Consumer center care
- 3) Leadership development with focus on diversity

She spoke about the importance leadership development and work force development. She gave a couple of caveats. They have learned they need to improve math and science skills in elementary school.

She used quote from Betrayal of Trust book, “The health of each is dependent on the health of all”.


They also feel prevention is better than cure.

She left group with quote from Martin Luther King. “Philanthropy is condemnable but...it must not cause the philanthropist to overlook the economic injustices that makes philanthropy necessary.”

BREAK

George Howell began panel discussion on Indian Health Appropriations: Entitlement vs. Discretionary. He introduced Senator Albert Hale.

Senator Albert Hale said it is an honor to join participants. He explained basis of relationship between federal government and tribes. He said that although tribes are sovereign, they are limited and that courts, legislature, etc bring on limitations. It is important for tribes to confront legislation brought on by state dictation. He gave several examples of that. He believes there is another entity that Indian Nations have not tapped into and that is state government and state funding. After all, Indian individuals are also citizens of states in which they reside. You need to be ingenious, etc., in these difficult times of low funding that was promised to Indian Nations. Healthcare was one of those services promised to Indian people. There is still commitment from federal government for health, and its only right they should do that, because it is the federal



government who has put us in this state. Diabetes, Alcoholism, etc.; he points to federal government as being the sources of those diseases. He spoke about how he pities Iraqi and Afghan people for receiving surplus foods from US government.

He said we need to figure out how to address funding mechanisms. When he was Navajo President there was a meeting with President Clinton that produced promises of respect, honor treaties, deal with us in sovereignty basis. He said he has always heard that and the moment you walk away from meeting that means nothing. He wrote letter to President Clinton saying that. He listed ways he thought those statements could really come to life. One of those was, 'why are you always forcing us to come to Washington and remind you to remember your obligation to Indians? Then, after that we must fight for money. Instead of forcing people to come to Washington why not do it by entitlement.' He said if they can't deliver on promises, then we need to go in direction of reclaiming resources. He spoke about how Senator Slade Gordon was trying to cut funding if Indians didn't give up sovereignty. He said he reminded them that if that were done, we would have to take back resources. We need to become more self-sufficient. We need to take responsibility for that, even though federal government fails in there promises we must make sure we are healthy. If we are not healthy people, there will be no healthy sovereignty. He spoke again about tribes needing to look to states for unmet funding needs. He has noticed that in some places there is no Indian lobby. As a state legislator it is often left to him and other Indian colleagues to track bills, funding, etc. Tribes need to hire lobbyists, get the vote out, etc. That effort will produce many benefits. Historically, we have not done that. We need to learn how to play the game.


George Howell introduced Tony Secatero.

Tony Secatero said he is glad to be here. He introduced Albert Ross. He said the many hardships on IHS, as well as tribes, are what we do from here on out? Discretionary monies are appropriated annually. When are we going to look at mandatory funding or entitlement?

IHS is at bottom as far as discretionary funding. Funding comes through several steps. By the time it gets to IHS and IHS Headquarters gets their share, by the time it gets to clinic you might as well close your doors. People are turned away because there are very little funds. Director of IHS has a difficult job. We also make it difficult on IHS by contracting shares, etc. He spoke about Albuquerque Service Unit and how pulling out money has affected that service unit. The US government has a trust responsibility. They also have due process. It is often our fault as tribes not to communicate health disparities for tribes. He spoke about line items within IHS budget formulation. When they get into details, tribes start thinning the budget and adding additional line items. We must learn how to share. We must also learn how to process the line items. Everyone seems to be doing their own thing. Why can't we all get together to secure more funds?

BREAK

Jody Abe began panel called Documenting the Need: Information as Power. She thanked National Indian Health Board. She introduced Ralph T. Bryan.



Ralph T. Bryan thanked organizers. He said he would set stage with data 101 information. He spoke about how important it is to understand what data means. Usually when we talk about data we are talking about:

- 1) A “health event”-a specific ailment
- 2) Behaviors-Health risk data
- 3) Health knowledge-what do I know about my own health?
- 4) Access and utilization
- 5) Vital statistics- births and death

How do we collect data?

- 1) Chart review
- 2) RPMS system
- 3) Ongoing vital statistics in very state
- 4) Periodic surveys
- 5) National Surveillance

There are challenges to data collection:


- 1) Access to people
- 2) What is research purpose, informed consent, review board issues
- 3) Accuracy
- 4) Racial misclassification
- 5) Timeliness
- 6) Representativeness
- 7) Data sharing and dissemination
- 8) Privacy and confidentiality
- 9) Jurisdiction
- 10) Analysis and interpretation

He talked about how tribes receive various data reports. He mentioned several publications that tribes receive for data.

Jody Abe introduced Keith Longie.

Keith Longie said with regards to RPMS, in several presentations data and information was mentioned often. He gave history of RPMS system. It was developed as a result of a group through IHS to find out how to answer necessary data questions. In February 1984, they needed info system quickly as budget cuts, etc. Key thing in RPMS is that data system be available at local level. Today, RPMS includes everything Dr. Bryan talked about and also data for billing. He introduced people in audience who have worked hard to implement the HR system. The new product is PAMS or patient account management system. There are several tribes working on this. RPMS is focusing on patients. For third party billing PAMS reconciles differences between encounter and patient. They are working on web based programs also. Today you can get GPRA PLUS. Takes all standard GPRA measures, but you can call on them locally and then compare service units. IHS Performance Evaluation System (IHSPES) for accreditation purposes. They are working on MIS training methodologies.

Security requirements should be made even better for patients. We do not collect Vital statistics data, and that is because it is responsibility of state. We plan to merge that



data in data warehouse. Eventually you will be able to see USER pop information from month to month. Data quality is an issue that has been brought up. It needs to be as high quality as we can make it. He stated that they do data audits.

Jody Abe introduced Cliff Wiggins.

Cliff Wiggins said he is pleased to be here. He stated that it is critical to get information together to make things happen. What they have learned working with IHS, Congress, etc. is that you have to have your information together. Items he thinks are most relevant to participants:

- 1) Story of what happened to IHS funds in last ten years or so. He gave history. Federal appropriations have gone up. But cost for providing healthcare has gone up and there are more patients to serve. Essentially, system is in same shape as in beginning.
- 2) How does IHS funding compare with other federal programs? Facts show IHS funding is less than Veterans Administration, prisons, etc. There is an obvious pattern there.
- 3) If we can't compare funding with other programs, can we find simple direct measure that Congress and other federal officials can understand? He thinks we can. He spoke about a program to insure same healthcare program that federal employees have. Congress can relate to that.
- 4) Per person funding across IHS shows funding differences between levels of funding for tribes in different Areas. He said there was never enough money to make those gaps go away.
- 5) If we had more money we could close some of those gaps.

Jody Abe introduced Jenny Jenkins.

Jenny Jenkins said she would address her remarks as local management issue. She spoke about Cass Lake hospital. She relies greatly on data for third party funding because they are very under funded. Her experience in Area office helps her as CEO because she knows necessity of data for planning, etc. Her major priority is to make sure staff has info so they can provide quality healthcare to patient. They are working to put in computers in each room. That requires support training locally and nationally. It also requires they have data entry people. This has changed priorities. They want the data to be shared. She uses data everyday to make decisions. She feels making decisions without data is a gamble. She spoke of challenges of getting data:

- Needs to be in usable form
- Must be presented to people so it has value.
- Need to keep up with technology
- How we use it to tell our story

Jody Abe spoke about challenges faced tribally, like a change in employees, etc. Without a plan, we won't get message out.

ADJOURN

Friday, June 4



Carole Anne Heart called meeting to order.

Chief Nelson Wallulatum, Warm Springs Tribe, Oregon gave the opening prayer.

Carole Anne Heart gave announcements. She called for definitions of Direct Service Tribes by Area.

Jody Abe said we must pass on traditions to future generations. She said a definition from Phoenix Area would come later.

Carole Anne Heart introduced Chris Walker.

Chris Walker gave the Oklahoma Area report. Their Area has a couple of resolutions to present to Dr. Grim. He said Directs Service Tribes are tribes that have exercised their options under PL-93-638 to require the IHS to continue to provide direct healthcare to all American Indians and Alaska Natives in the service area. They don't abrogate their option under PL-93-638 to at any time assume IHS services through a hybrid contracting method under Title1Self-Determination or Title 5 Self-Governance.

Carole Anne Heart introduced Hilda Moss.


Hilda Moss said the Methamphetamine problem on their reservations have deteriorated their families. So they have been talking about forming more partnerships to address problems. She encouraged everyone to look at CHS document. It takes congressional action to change that language. She read position statement about the healthcare situation on the Blackfeet reservation from the Blackfeet Tribe that will be forwarded to Dr. Grim. She thanked meeting participants.

Carole Anne Heart introduced Mathew Tomaskin.

Mathew Tomaskin thanked staff of Direct Service Tribes planning. He said 2nd annual DST conference would be even better. He gave Portland Area definition of a Direct Service Tribe. He said all Portland Area tribes are Direct Service Tribes and Treaty tribes and they leave their funding in the area office. The DST's often have to bail out compact tribes who run out of money. Again, they believe a DST is a Treaty tribe.

- 1) DST's will all collaborate together before inviting other groups to participate in joint meetings
- 2) To formulate group thinking and develop internal policies unique to DST's.
- 3) Establish goals
- 4) Identify health disparities
- 5) Identify funding disparities
- 6) Allow time for other DST not here to learn about our work here and submit their work
- 7) Networking links among DST's
- 8) DST's will develop training format for new leaders and legislators

Carole Anne Heart introduced Jenny Jenkins.



Jenny Jenkins gave Bemidji Area definition. She said at least a portion of the program is operated by IHS so they have a stake in the community.

Future goals include:

- Expansion and improvement of services at service unit and tribe.
- Strengthen infrastructure
- Continue to merge tribal and IHS programs, and make them seamless
- Establish electronic health record.

Challenges:

- New tribal elected officials
- New policies
- New ideas
- Funding
- Recruitment
- Influx of new patients
- Information technology

Recommendations:

- All tribes be funded at least 60% of LNF or health disparity index
- IHS pay for elders, Medicare premiums either directly or reimburse elderly
- DST office at Headquarters
- Support Dr. Rhoades and Mr. Roach that DST receive allowance at beginning of year for investment
- Streamline personnel, procurement and financial services
- Centralizations of compacted tribes at headquarters
- Similar funding of contract support cost to DST's.

Carole Anne Heart introduced Rosemary Lopez.

Rosemary Lopez, (inaudible). ...Some of the leaders are very outspoken. (inaudible)...The question she has is that when they take their money, DST's need to bail them out. We need to have another meeting. We should start planning that right now. It should be in 6-8 months, not a year. They recommend another year, (inaudible). One of the other things is, (inaudible). We should focus on behavioral health...alcohol and substance abuse, etc. (inaudible). That affects chronic disease and education.

Carole Anne Heart introduced Evelyn Acothley.

Evelyn Acothley introduced Navajo Nation delegation. She thanked NIHB and IHS. She introduced Alice Benally.

Alice Benally gave definition for Navajo Nation.

- Those Indian tribes who continue to rely on IHS to deliver health services because of treaties
- DST's must have greater role in administration and operation of IHS programs
- We believe the theme "As long as grass grows and rivers flow" should be kept until charter is done by DST

-
- A technical work group be established and funded by Dr. Grim for DST planning committee
 - Should be second annual meeting
 - Consider treaties as a topic. Where they originate and how they impact us today as tribes.

Evelyn Acothley gave future of Direct Service Tribes. She gave the introduction. She said Navajo Nation set strategic goals to promote quality of care.

- Improve, coordinate and expand services
- Improve government-to-government relationship at state, regional and national level
- Improve healthcare manpower and education
- Strengthen healthcare with existing healthcare providers
- Strengthen M.I.S.
- Comprehensive data systems
- Maintain adequate health facilities
- Develop and regulate health agencies

Future Goals:

- New facility Construction
- Sanitation Facility Construction
- New technology
- Partnerships and agreements
- Services, Trauma Center systems
- Move to tri state regional consortium
- Alternative Resources
- Funding disparities
- Medicare funding
- Strengthen oversight authority of 638 providers
- Behavioral health facility
- Nursing homes




Major Challenges:

- Economic status
- Recruitment of professionals
- Rising cost of healthcare
- Increasing population
- Educating congressmen

She gave her conclusion. (Inaudible)

Carole Anne Heart introduced Governor Roland Johnson.

Governor Roland Johnson gave draft statement from Albuquerque Area. He said DST's have made a choice to get health services directly. We choose to have federal government administer funds. Regardless of who administers funds, tribes must have an active partnership in relationship. If DST's are to make progress the must be adequately funded. The need to replace health care facilities is paramount. Many Indian



hospitals are in bad shape. That poses a health threat. Lastly, Indians must be recruited to enter healthcare field. They define DST's as hybrids. Several tribes contract several health programs. Common areas of concern:

- Insufficient areas of funding
- Participation in decision making
- Service to individuals from outside service area
- Substance abuse programs
- Behavioral and mental health issues
- Elder care
- Facilities
- Staffing

Specific Tribal issues:

- Radiation exposure
- Homeland security
- Jicarilla Apache Nation commitment of healthcare facility
- Reduced LNF by Bush's administration
- Training
- Cultural Sensitivity of healthcare staff

Recommendations for next year conference:

- Inclusion of DHHS programs
- Workshops
- Participation from OMB

Carole Anne Heart introduced Chairman John Blackhawk.

John Blackhawk made suggestions for next year's conference. He thinks the first day of conference should be used for suits and ties, and blue jeans after that. He thanked Dr. Grim. He believes everyone should support resolution of support for Dr. Grim. He introduced IHS staff from Aberdeen Area office. He thanked National Indian Health Board staff. He thanked area caucus people.

Future goals of Aberdeen Area:

- 1) Indian Health Care Improvement Act
- 2) Educate Congressional committees about tribal health needs.


Major Challenges

- Not enough staff to meet health disparities

Major successes:

- Tribal representatives that go to national meetings to represent us
- Funding and support for Direct Service Tribes meeting
- Coalition building with other areas

They also discussed Dr. Rhoades position paper. The Aberdeen Area caucus decided to accept that document with small changes applicable to A.A. He spoke about the



document and how relevant they are to other areas. Finally, at some point he thinks there should be reps in all areas for DST. He feels partnerships should be continued. He thanked committee. He said panel discussions were wonderful with excellent speakers.

BREAK

Carole Anne Heart introduced Oklahoma Area representative.

Chris Walker said they have a goal to double number of delegates next year. He spoke about Cherokee treaties of New Echota. He said as a result of the New Echota treaty, Cherokees have a seat in House of Representatives starting this year.

- Direct Service Tribes needs to have a stronger voice in ITU network
- Educate Congress on staggering lack of funding
- Necessity of sharing info by OMB during budget pass backs
- Inequity of Direct Service care and Contract Health funding
- Passage of Indian Health Care Improvement Act
- More effective collaboration of tribal health service boards and Area office
- Greater part in decision making in ITU process
- Need to become more educated in ITU

He said theme for the conference, “As long as the grass grows and rivers flow”, is excellent but could add, “As the sun rises in the east and sets in the west, we are still here.”

Future goals:


- Provide a comprehensive briefing on ITU's
- Form work group to address budget disparities
- Provide briefing on ITU's on Indian Health Care Improvement Act
- Insure maximum participation of Service unit health boards to budget process
- Provide cohesive planning effort for ITU for sharing best practices
- Explore additional resources, partnerships, etc.

Challenges:

- Ensure more parity of resources in ITU budget processes.
- Unification of Direct Service Tribes
- Determination of message
- More efficient management of Contract Health resources
- Inclusion of all ITU health professions

Successes:

- Participate more effectively in budget process
- Speak with one voice to Congress
- Better justify additional resources
- Understanding of Intricacies of IHS budget process

- 
- Make commitment to double number of Direct Service Tribes conference participants

Recommendations:

- More time allotted for panelists
- Commend planning committee, etc.
- Have meeting in D.C.

Carole Anne Heart introduced Jody Abe.

Jody Abe said all the goals in Phoenix Area scream for more funding. Until we get on same platform, we need to use time in DC to demand more funding. Treaty tribes have valid request for payout. Conference theme should stay the same.

Carole Anne Heart introduced Portland Area representative.

Garland Brunoe said with regards to Health priorities of Direct Service Tribes. He gave a budget breakdown of priorities needed:


- Primary Care
- Prescription drugs
- Program increase
- Joint Venture small specialized facilities
- Diabetes
- Elder healthcare
- Behavioral Health
- Information Technology
- Dental
- Nutrition Obesity
- Health education
- Injury Prevention
- Cancer Prevention
- Respiratory

Asked meeting participants to contact Area reps with suggestions for next year's conference.

Carole Anne Heart introduced Albuquerque Area representative.

Amadeo Shije said we learned from our mistakes for planning the conference. He said the next conference will be a lot better. He gave an example of Gathering of Nations pow-wow history. We will continue to dialogue. He's heard a lot of talk of having a unified effort. That is important in order to get word to Congress and federal agencies. He spoke about political atmosphere in Washington DC. It might be best to hold next conference in Indian Country; at an Indian-owned facility. He feels overall the conference went well.

Carole Anne Heart introduced Navajo Area representative.



Frank Dayish, Navajo Nation Vice-President said the Navajo Nation recommendations for next year's conference:

- Healthcare facility construction
- Water and sanitation projects
- Injury prevention
- Behavioral health
- Cancer
- Diabetes
- Heart disease prevention
- Dental
- Communicable disease prevention
- Elder care
- Maternal child health care

Navajo Nation will continue to work on Medicaid related issues. He spoke about how changes in Medicaid are affecting Navajo Nation that is located in three separate states. CMS needs to educate tribes.

- Facility renovation
- Behavioral health facilities
- Passage of IHCA

Thanked Dr. Grim for recognizing DST and asked for his continued support.

Carole Anne Heart introduced Bemidji Area representative.

Jenny Jenkins also agreed to the theme but wanted to add what it means to our future. She suggested to narrow conference objectives to give more time to discuss topics, and to use meeting to develop strategic plan for national basis.

Carole Anne Heart introduced the Billings Area representative.

Hilda Moss thanked Dr. Grim for conference. Said she forgot to mention diabetes as priority for her tribes. She recognized her diabetes coordinator. She supports the same theme for next year. She suggested participants report milestones that came from this conference, like partnerships, etc. She said to narrow priorities to Washington, DC

Carole Anne Heart introduced Garland Brunoe to give Wrap up.

Garland Brunoe said the impact on him was there was actual life breath being given back to DST and hope for people back home because of this conference. He highlighted some good things he heard throughout the days of the Conference:

- John Blackhawk statement that its all of us together Direct Service Tribes and self governance tribes
- Don Kashevaroff that we should all be offended about our healthcare compared to mainstream
- Dr. Grim statement that healthcare has to do with spirituality, the emotional and physical side of people
- George Howell said we should listen to our culture

-
- Vivian Juan-Saunders talked about the importance of clear data
 - Dr. Rhoades talked about individuals with authority, paradigm shifts, and the IHS parameters
 - Rachel Joseph talked about consistent message to DC
 - Jerry Freddie talked about elder's vision of educating young people.
 - Dr. Kathy Annette talked about networking of IHS tribes, and Urban programs and Wisdom Steps program
 - Keith Longie talked about importance of ownership of our data using RPMS
 - Jennifer Farley said theme of administration is that together we can solve all problems
 - Senator Inouye and Congressman Rick Renzi said we need your input. They are waiting for our lead
 - Tex Hall talked about the NCAI Apology Resolution.
(<http://www.ncai.org/data/docs/legislative/2004/04-041.pdf>)
 - Michael Hughes said next 4 years would not be easy because of war, weak economy, etc. We need accountability and integrity.
 - This conference location was selected based on the timing and cost.

Carole Anne Heart introduced her Area for wrap up.


John Blackhawk said he applauds effort of Navajo Nation of bringing young people. He said we absolutely have to bring young people here. He said that there was not enough time for dialogue. He introduced people from Lame Deer to speak.

Carole Anne Heart introduced Dr. Charles Grim.



Dr. Charles Grim thanked everyone who worked hard to put conference together. This really was a tribally driven conference. He said that for a tribe to remain a Direct Service Tribes, it's always a show of self-determination. He said doing things like this conference is a step to be visible nationally. When he gets home, his plans are to:

- Ask for copies of comments from Areas to see how changes might have to be made in the law, like making IHS an entitlement program, etc. So, some things require changes in law, appropriations and/or priorities
- Changes in organizational structures are more in IHS control
- Asking for health in interfacing with other agencies. IHS can help with that
- Another category is information gathering, presentations, networking etc. They need to categorize those. He will ask Area Directors to work on those in July. As the IHS Director he has to answer to a lot of people.

- 
- One of the things they can do is see if there needs to be something more specific in Doug Black's Office of Tribal Programs to provide some sort of assurance that there is a location DST's can go to deal with issues.
 - Need to get Indian Country Issues onto regional and national levels.
 - He attended Cherry Creek, South Dakota pow-wow and that was important to get out and meet with people on their lands.

He stated that Direct Service Tribes are most direct customers, the ones they should be doing the most things with he feels conference was successful and that participants got a chance to network. He assured participants that rights would continue to be honored and they will be consulted on programs. He appreciates opportunity to spend two and a half days with participants. He feels we're all in this together. He appreciates the work done by participants. He hopes IHS can live up to issues.

Carole Anne Heart thanked Dr. Grim. Asked honor guard to close and have a flag song.

George Howell gave closing prayer

Honor song was sung

Colors were retired


ADJOURN





Area Caucus Guidelines and Reports





Area Caucus Information and Guidance

The caucus sessions are provided for Areas to gather and reflect upon the day's events to work toward accomplishing the conference goals. You should discuss topics that are of importance to your Area and gather strategies, questions and goals. The Area Representative to the Direct Service Tribes Planning Committee will facilitate the caucus sessions and the group should elect one or more speakers to present at **two separate sessions** on the final conference day (See agenda).

The Future of Direct Service Tribes

Prepare a short statement (200 Words) about the future of the Tribal Governments in your Area. Concentrate of common themes and goals.

- What are the future goals of your Area over the next year?
- What are the major challenges you may experience over the next year?
- What are the major successes you may experience?
- Was there a session that was of particular use and help?

Determine the Definition of Who We Are as Direct Service Tribes

Prepare a definition of Direct Service Tribes (100 words or less); consider the following:

- Self Governance, Title V
- Self Determination, Title I
- Direct Service
- Hybrid – 638 and Direct Service

Next Year's Conference Development

Look at the conference mission statement, tracks and objectives to develop items for next year's conference.

This Year's Mission Statement: “As long as the grass grows and the rivers flow...”

This Year's Tracks:

- Federal Perspectives on the Budget Process;
- Tribal Perspectives on the Budget Process;
- Regional IHS Director's Panel,
- Upholding the Federal Responsibility; Building Opportunities, Networks and Partnerships, “*Expanding the Relationship*”;
- Indian Health Appropriations: “*Entitlement vs. Discretionary*”;
- Documenting the Need, “*Information as Power*”.

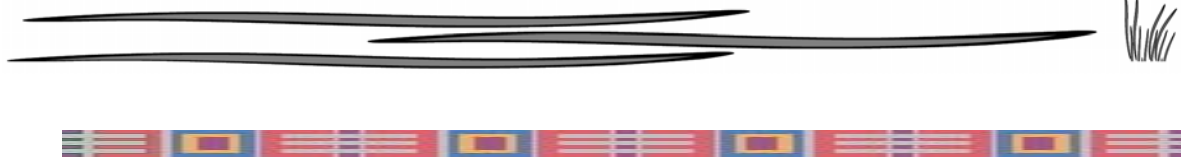
Conference Objectives

- To Improve Healthcare Delivery
- To Develop Strategies to Effectively Reduce Health Disparities
- Define the Unmet Needs of Direct Service Tribes
- To Discuss and Understand Federal Entitlements
- To Clarify and Strengthen the Budget Process and Budget Allocation
- Create New Partnerships and Alternate Funding Sources
- Clarify and Identify Proper Methods for 3rd Party Billing



Aberdeen Area Caucus Report





Aberdeen Area Caucus

Direct Service Tribes Conference
Pointe South Mountain Resort
Phoenix, Arizona
Wednesday, June 3, 2004


Future of Direct Service Tribes:

What are the Future Goals of Aberdeen Area over the next year?

1. Insure passage of the Indian Health Care Improvement Act
Go for straight reauthorization, no changes to insure passage so we have full operating funding for programs and not have the Administration make decisions about eliminating programs or making administrative decisions that are adverse to Tribes during interim.
2. Support the formal creation of the Direct Service Tribes Organization
 - a. Develop By-Laws
 - b. Push for Second Annual Meeting
 - c. Insure a seat at the National Workgroup Meetings
 - d. Fund an Office for Direct Service Tribes in 2004, including a dedicated position to respond to DST
3. Educate key Congressional committees about Tribal Health Needs specifically Aberdeen Area Tribal needs that are disparate compared to the other twelve areas of Indian Health Service and to the general U.S. population
4. Make available to all Aberdeen Area tribes the list of appropriate Congressional Committees Tribes need to educate i.e. Appropriations, Health, etc. in order to increase the budget for Health.
5. Educate the local tribal population about getting out to vote correctly.
6. Move faster to contract AAIHS programs that can benefit all Aberdeen Area Tribes in the area of legislation, information, education and hosting of meetings to increase the level of education of both Tribes and Congress.
7. Devise a revenue enhancement strategy for the Area.
8. Implement the Strategic Long Range Plan insuring it includes exposure of Health Needs as a national priority.

What are the major challenges?

1. Rallying support within the Area Tribes for passage of the IHCA
2. Not enough staff or funding to disseminate our position widely.
3. Providing information to all AA Tribes about the IHCA.
4. Development of a Position Paper on the IHCA for distribution to all Tribes.
5. Lack of funding and support for activities that will educate tribes about the IHCA and other initiatives to educate AA tribes about health care needs.

- 
6. Not enough staff and people to address the great disparate needs of Aberdeen Area tribal people
 7. Need for more health and demographic data about the Aberdeen Area population
 8. Not enough funding for staff to work on AA issues through a strategically fashioned information and media campaign.

What are the major successes?


1. Involved and committed tribal leaders who attend and represent Aberdeen Area at the National Meetings, i.e., NIH, TTAG, Budget Formulation, Diabetes, FAAB, NCAI, DST, etc.
2. Funding and support for the Direct Service Tribes Meeting.
3. Coalition building with other Areas such as Billings, Navajo, Bemidji, etc.
4. Greater involvement on the national scene by the AATCHB Chairs and staff
5. Development of an interactive Website for use by Tribes
6. Moving forward on contracting I.H.S. programs
7. Good choice for AAHS Director, Don Lee from Cheyenne River
8. Better representation through aggressive advocacy and representation on NIH
9. Development of a Strategic Long Range Plan for Health.
10. Establishment of a strategic plan to implement the health priorities.
11. Creation of a position for Tribes on the AALC.
12. Greater and closer working relationship with AAHS.
13. Creation and establishment of the Northern Plains Tribal Epidemiology Center (NPTEC) with requisite staff, i.e., 2 American Indian epidemiologists and growing professional staff.

Definition of Direct Service Tribe:

Majority of services still maintained by the Indian Health Service for the Tribe, whose choice is to hold the federal government to it's treaty and trust responsibility obligation as an expression of self-determination.

Aberdeen Area Strategy and Outcomes:

1. Identify key officials in the Bush Executive Branch and the key Secretaries that need to be educated
2. Develop an Impact Week to be held in DC for the Aberdeen Area Tribes at a time (Maybe February 2005 or September of 2004) that is beneficial for providing education and dissemination of information to Congress
3. Develop a package to be sent to Law Firms representing the Tribes that can respond adequately to the guidelines set forth by Aberdeen Area to hold an Impact Week in DC
4. Develop a informational packet pertinent to the health issues and needs of Aberdeen Area tribal population
5. Organize the Aberdeen Area to submit their tribal specific health needs for inclusion in the packet for information dissemination

- 
6. Capitalize and use data from the RPMS, GPRA Plus, Trends in Indian Health, and other sources that can support our position on the existing health disparities
 7. Distribute widely the report prepared by Everett Rhodes, MD and Howard Roach titled: "Direct Service Tribes: Historical Perspectives on Consideration of their Present Status," and use to develop an innovative strategy to strengthen the role of DST
 8. Develop strong collaboration with other Areas that share our perspective on Health Care or who share similar conditions or positions.
 9. Partner with other national organizations and other partners to promote DST position to gain greater funding for IHS above the 2.9 billion dollar threshold submitting by the Department.

Prepared by:

Carole Anne Heart, Executive Director
And AATCHB Caucus

Presented by:

Chairman John Blackhawk, Winnebago Tribe of Nebraska
Chairman of the Board of AATCHB





Albuquerque Area Caucus Report





Albuquerque Area Caucus Report

**Submitted by the All Indian Pueblo Council Chairman
Developed by the Albuquerque Area Caucus**

**Submitted to the
Department of Health & Human Services And the Indian Health Service**

**Phoenix, Arizona
June 4, 2004**

I. Introduction

This draft statement reflects the views and concerns of the following Direct Service Tribes (DST): Pueblo of Laguna, the Jicarilla Apache Nation, and the Mescalero Apache Tribe. We plan to circulate the statement to all DST's in the Albuquerque Service Area for their review and comments. Upon finalization, we will formally submit a final statement to the Department of Health & Human Services (DHHS), the Indian Health Service (IHS) headquarters and the IHS Albuquerque Service Area.


The statement is organized as follows:

- Future of Direct Service Tribes
- Definition of Direct Service Tribes
- Common Areas of Concern
- Tribal Specific Issues
- Recommendations

II. Future of Direct Service Tribes

Direct Service Tribes have made a self-determination choice to have the federal government deliver healthcare directly. We realize many tribes feel a need to administer federal dollars that are owed them. We, however, have made a different self-determination decision. We choose to have the federal government administer the federal funds owed us and thereby maintain its responsibility to uphold treaty obligations. Regardless of who administers the funds, it is of vital importance that the federal government allows DSTs to have an active partnership in this relationship.

If DSTs are to make significant progress in improving the overall health of Indian people, the IHS must be fully funded. The IHS budget allocates \$1,914 per Indian for healthcare while the federal Bureau of Prisons budget allocates \$3,803 per inmate for healthcare and the federal Veteran's Administration budget allocates \$5,214 per veteran user for healthcare. See February 2004 Executive Summary Report of the U.S. Commission on Civil Rights, Office of the General Counsel. This disparity in funding between Indian and non-Indian federal health care is unconscionable. Each year, Indian Tribes must implore Congress to restore or increase funding the IHS. For FY 2005, this is again the case.



Second, the need for replacing, repairing and rehabilitating healthcare facilities is paramount if the future of DST healthcare is to be secure. Most Indian hospitals and clinics are dilapidated and unsafe. Likewise, other types of healthcare facilities are needed such as a regional treatment facility, trauma facilities, and elder care centers. Surrounding infrastructure such as sewage lagoons, water delivery systems, and electrical systems need to be repaired or replaced as they posed a health threat or interfere with the timely delivery of quality healthcare services.

Last, young Indians must be recruited to enter the healthcare profession. By this we mean doctors, nurses, technicians and other related professions such as finance, management, and policy. In addition, to the tremendous turnover of doctors and nurses, healthcare facilities, which provide services to DSTs, are often grossly mismanaged and understaffed.

III. Definition of Direct Service Tribe


For the IHS Albuquerque Service Area, we define DSTs as “hybrids”. Several Indian Tribes have contracted some aspects of their healthcare services (e.g., the Pueblo of Laguna has contracted the Substance Abuse and Mental Health programs under P.L. 93-638), while others like the Mescalero Apache Tribe have insisted upon federal administration and delivery of their healthcare services as a requirement of the federal trust responsibility toward the Tribe.

IV. Common Areas of Concern

Insufficient Funding - Again, if DSTs are to make significant progress in improving the overall health of Indian people, the IHS must be fully funded. Last year, the Administration touted a 1.2% increase in IHS funding. This was grossly insufficient. Such funding does not make up for the historical under-funding or factor in inflation. In the last session of Congress, Senator Tom Daschle (D-SD) proposed a 10% increase in IHS, but his proposal was defeated. We urge the Administration, the DHHS, and the IHS to increase next year's IHS budget by 10% during the budget formulation process. This would give Indian Tribes a fighting chance of keeping the proposed increase intact as it makes its way through the Congressional budgetary and appropriations process.

Participation in Decision Making – DSTs must be active participants in the local and national decision-making process. Many hospitals have local health boards, but these boards are often told that they serve as advisors and are not included in policymaking or personnel hiring. DSTs have an inherent interest in ensuring that policies are fair and that the personnel that will be serving tribal members are qualified and sensitive to needs of the people. In one instance, the Pueblos were not consulted with respect to the UNM Indian Hospital. The IHS transferred Indian trust land to the county for the purpose of a new hospital for Indian people and the general public. Although DSTs are consulted and invited to meetings, the end results are discouraging, as our recommendations do not survive the process.

Service to Individuals from Outside Service Area – There is often “double dipping” in delivery of services. This results from the “open door” policy of the IHS. For instance, the large Navajo population in the City of Albuquerque often uses healthcare facilities and services of surrounding Pueblo service units. As a result, the funding for the local service units is being used for the Navajo population and the rightful users in the service are being denied or delayed services. Further, there is no mechanism to recover these costs.



Substance Abuse Programs – There is a high rate of alcohol and drug abuse on Indian reservations. The IHS does not have sufficient funding for substance abuse programs. As such, we reiterate that Indian Tribes must be active and involved participants in the budget formulation process. Further, the needs of Indian Tribes are not considered a priority of other DHHS agencies and programs such as SAMSA, HRSA, and CDC. A formal process for consideration of tribal substance abuse issues by the whole of DHHS must be developed.

Behavioral & Mental Health Issues – Despite a recent infusion of resources into these programs, such programs are making no progress. In some cases, the rate of suicide and domestic violence continues to soar. One way to address this is for the IHS and the DHHS to bring their expertise to the table. DHHS has other programs that deal with such issues and perhaps there are successful models that can be adapted to a Native American population. Currently, the IHS conducts yearly evaluations that concentrate on service statistics and fiscal management – in which the evaluation criteria is unclear and the follow up is scant.

Elder Care – Indian people have traditionally respected their elders and sought to provide the best healthcare for them. Currently, the IHS does not have the statutory authority to build elder care centers. Further, there is little money for much needed programs such as physical fitness and nutrition counseling.

Facilities – Several areas of concern exist here. Most facilities are aging and if they are not repaired, rehabilitated or replaced in a timely manner, they will become dilapidated and unsafe. The existing facilities often do not meet industry standards. Often, the facilities were built for one purpose but used for another. For instance, one hospital was originally built to be used as a sanatorium. Also, other types of facilities are needed such as elder care, youth treatment, and dialysis centers. It is our understanding that the facilities priority listing will be released for comment later this summer. Again, we must express our frustration that DSTs have not been consulted in the formulation of the priority listing.


Staffing – Area hospitals and clinics are understaffed and continually face tremendous turnover. This shortage of staff results in poor care. Much of the turnover is due to the remote location of many DST service units. Although good salary and benefits may be an incentive we would like to work with the IHS to address some of the quality of life issues that may arise as reasons for the frequent departure of doctors and nurses. Also, each new hire should receive cultural sensitivity training. This can only help the person provide better services and encourage retention. The staffing problem is further compounded by vacancies going unfilled for months. Each time, a doctor or nurse leaves, the trust and confidence of the community is lost. Having to see a new doctor or nurse with each visit creates an environment of apprehensiveness. Again, we urge DST involvement in the selection process of new personnel. Local community members and tribal leaders add the benefit of community involvement in the delivery of healthcare and can provide an inroad into the community for the new person.

V. Tribal Specific Issues

Pueblo of Laguna (Radiation Exposure and Homeland Security)

Radiation Exposure

Since the federal government, in partnership with private companies, began mining for uranium for the sake of national security and World War II, Laguna people have had an increase in cancer



and other related illness that can be traced to radiation exposure. Several years ago, Congress passed the Radiation Exposure Compensation Act that provides for screening, treatment and possible compensation for person(s) whose health may be adversely impacted by working in uranium mines or mills. IHS must provide necessary services to provide screening and treatment services.

Homeland Security

The Laguna reservation is bi-sected by Interstate 40 and the railroad. It is no secret that the Interstate and the railroad are used to transport hazardous material such as radioactive waste. Transport of these kinds of hazardous material leaves the Laguna reservation vulnerable should an accident occur or an act of terror occurs within the reservation. The Laguna-Acoma hospital is not prepared or equipped to deal with such an emergency. Secretary Tom Ridge recently released more First Responders money to the States, but Indian Tribes are not eligible for direct funding. We implore Secretary Tommy Thompson and IHS Director Dr. Grimm to assist Indian Tribes to secure First Responders funding from the Department of Homeland Security.


Jicarilla Apache Nation (Joint Venture Health Care Facility): In August 2002, the Jicarilla Apache Nation ("Nation") signed a "joint venture" agreement with the IHS under which the Nation committed to providing land, the planning and design funding and non-federal money for the construction of the facility. The Nation also agreed to execute a no-cost 20-year lease to the IHS for the operation of the facility. Under the agreement, the IHS contracted to lease the facility from the Nation, to provide equipment and staffing for the facility during the term of the lease, and to maintain, repair and improve the facility. With respect to staffing, the IHS expressly committed that it would not request funding "at any level below 85% of the need identified in the Project Justification Document." The agency has interpreted this language to essentially be the equivalent of 85% of the amount of funding for construction.

Last year, the Nation broke ground on the new facility. The Nation has met all of its contractual obligations. Construction is expected to be completed in mid-September 2004. The Nation spent \$10.4 million on constructing the new facility and \$1.5 million for related staff housing quarters. The IHS provided \$3.5 million for equipment, and \$60,000 for the Nation to hire a contractor to equip the facility.

The President's FY 2005 Budget request includes approximately \$3.4 million for staffing purposes under our joint venture agreement. The amount is approximately \$5 million below the level of need of what was agreed to and intended under the agreement. The Nation respectfully asks DHHS and IHS to provide additional funding for staffing to a sufficient level. In addition, the Nation is requesting \$1.5 million for Congress to match the amount that the Nation will spend to construct related staff housing quarters.

In future years, IHS must adequately and sufficiently formulate a budget that meets its joint venture obligations to fully staff, maintain, and equip the facility. The Nation has met its obligations and the federal government must do so also.

Mescalero Apache Tribe (Relationship with the Tribe; Training): Relationship with the Tribe - The Mescalero Apache Tribe ("Tribe") maintains that it is the federal government's responsibility to provide healthcare to the tribal members and the Tribe is not interested in contracting healthcare services under P.L. 93-638. The IHS and the Mescalero Hospital Administration must accept this and make a good faith effort to work with the Tribe in the



delivery of healthcare services and developing and setting policy. The Tribe stands ready to be an active participant with IHS on hospital financial and service delivery issues.

Training

The Tribe would like to see more in-depth training for all old and new healthcare personnel. Such training should include the areas of contract health, securing and implementing contracts, and cultural training. Often, services to tribal members are delayed because there is a lack of timely referrals and completion of necessary paperwork. Likewise, there are many missed opportunities in securing grants that would improve the delivery and quality of healthcare services. Last, many hospital personnel have no awareness and understanding of the Mescalero culture and traditions. This lack of sensitivity is counter-productive to the healing and well being of tribal members.

VI. Recommendations for Next Year's Conference

Inclusion of DHHS Programs – We think it is imperative that information and discussion on more DHHS programs be included in the conference. DSTs receive service from other DHHS programs such as the Centers for Disease Control, Administration on Aging, and others.

Workshops – Though the general assembly panels were informative, several of the panels such as the budget and appropriations panel would have been better executed in smaller workshops or breakout sessions.

Participation of Office of Management & Budget – We believe the acute budget crisis that confronts DST programs makes it imperative that the Administration's budget planners actively participate in next year's conference, which should be scheduled at a time to accommodate their attendance.





Bemidji Area Caucus Report





DIRECT TRIBES MEETING – BEMIDJI AREA RECOMMENDATIONS

1. All Tribes be funded at least 60% LNF/ADI.
2. I H S either pay or reimburse elders for their Medicare premiums.
3. Office for direct tribes at I H S Headquarters.
4. We support Dr. Rhoad's and Mr. Roach's recommendations

including:

- A. Direct tribes receive allowances at the beginning of the year
and be able to invest the dollars.
- B. Streamline personnel, procurement, and financial services
allowing service units to hire directly, pay bills directly, and
delegate procurement authority to the local level.
- C. Centralize the compact tribal function a headquarters.
- D. Make funds similar to CSC funds available to direct service
tribes.





Billings Area Caucus Report (Unavailable at the time of print)





Navajo Area Caucus Report





Navajo Area



**Direct Service Tribal Meeting
Phoenix, Arizona
Navajo Area Caucus
June 1-4, 2004**

THE FUTURE OF DIRECT SERVICE TRIBES

Introduction

In June 2003, the Navajo Division of Health, in coordination with other tribal divisions and the Navajo Area Indian Health Service, identified eight strategic goals to address healthcare needs. These goals were developed to guide efforts toward improving the health status of tribal members and to promote quality of care. Each goal also requires communication and coordination with various Federal agencies, the states of Arizona, New Mexico and Utah, and the counties within those states.

The strategic goals are:


1. To improve, coordinate, and expand services;
2. To establish, strengthen, and improve Government-to-Government relationships at State, Regional and National levels;
3. To optimize health care manpower training and education;
4. To create and strengthen collaboration and partnership with existing healthcare providers;
5. To expand and coordinate infrastructure for information technology;
6. To access reliable and comprehensive data systems;
7. To construct and maintain safe and adequate facilities;
8. To develop a regulatory health agency

The Indian Health Service is the primary health care provider on the Navajo Nation. The Navajo Area IHS serves two federally recognized Indian tribes, including the **Navajo Nation** and the **San Juan Southern Paiute Tribe** and it also serves other eligible beneficiaries through inpatient, outpatient, contracts for specialized care, 638 Contract, and an urban Indian health program.

There are 3,931 staff working at six IHS service units, an Area Office, and three "638" Self-Determination contract providers. The healthcare network includes five hospitals, six health centers, fifteen health stations and twenty-two dental clinics. The Navajo Area IHS is responsible for providing health care services to more than 200,000 patients.

What are the future goals of your Area over the next years?

While working toward fulfillment of the identified goals of the Navajo Area within the next couple of years, we must also be cognizant of the funding constraints and existing health disparities that continue to impact the delivery of services throughout the Navajo Nation.



During the Indian Health Service budget formulation session for FY 2005 and 2006, the top five Navajo Area priorities were as follows:

1. Health Care Facilities Construction to continue funding for new and replacement facilities such as hospitals, health centers, staff housing, and other critical facilities.
2. Sanitation Facilities Construction (PL 86-121) Projects to continue funding for Sanitation (water, waste water and solid waste projects);
3. Diabetes;
4. Cancer; and
5. Behavioral Health Services.


The Navajo Area will continue to work on the previously identified health care priorities, which requires stable and additional funding. In addition, the Navajo Area caucus identified additional tasks that the Direct Service Tribe Consortium should consider in its overall strategic planning.

Suggested Future Goals

<p>Technology Use Technology to our advantage Expand Telemedicine Implement Electronic Health Record</p> <p>Traditional Medicine Fund and Preserve Traditional Healing Practice and Medicine</p> <p>Partnerships/Agreements Direct Service Tribes and “638” Programs Work Together Raise the Level of Care Collaboration and integrate Navajo Nation and NAIHS strategic plans Support one another and strive toward unity Adopt a feasible model from the Private Sector Employ effective Lobbying Strategies Work on Reauthorization of PL 94-437</p> <p>Services</p> <ul style="list-style-type: none"> • Expansion of direct healthcare services • Work on Trauma System/Center • Secure resources for Epidemiology Center • Expand Elder Care • Assistance Living • Review the Feasibility of a Navajo Public Health Department • Strong Health Promotion and Disease Prevention Service • Upward Mobility Program for Youth • Move towards establishing a Tri-State Regional Consortium 	<p>Alternate Resources Look at the possibility of collecting tribal Health Care Insurance Share Current Resources Make the Best Impact with our Resources Increase Joint Venture Funding Financial Survival Address Funding Disparities State Medicare/Medicaid</p> <p>Governance Organize/Revise and provide training to the Health Advisory Board Streamline and disseminate information in a timely manner Adopt a Model Organization for Direct Service Tribes Clarify Oversight Authority and Responsibility of PL 93-638 Contract Providers Stabilize and Strengthen PL 93-638 Contract Providers Protect and Uphold Trust Responsibilities Promote Unity – One Voice Regional Consortium under the Navajo Nation</p> <p>Facilities and Construction</p> <ul style="list-style-type: none"> • Increase funding for health care facilities • Continuous planning for healthcare/behavioral health facilities • Environmental Land Fills • Increase PL 86-121 Projects • Nursing Homes • Detoxification Center & Half Way House
---	---

What are the major challenges you may experience over the next years?

Like all other American Indian and Alaskan Native Nations, the Navajo Area continues to face a number of challenges to maintain and adequately serve the Navajo and San Juan Southern Paiute people. There are many factors to be aware of when planning for equality health care delivery system such as poor socioeconomic status, the general state of the national economy, the increasing population, the rising cost of health care, recruitment and retention of qualified health care professionals, inadequate and lack of housing, severely under-funded health facilities and programs, to name a few. There must be greater efforts to educate Congressional representatives and staff as well as federal, state, and other key partners in health care on critical health issues, sovereignty, treaty obligations, and trust responsibilities.



One of the many challenges facing the tribally operated programs is meeting accreditation requirements in order to provide quality care and to collect third party reimbursements. For example, the Navajo Nation secured several health care facilities that were previously owned and operated by the IHS. The Navajo Nation continues to invest substantial amount of resources to renovate and upgrade these facilities in order to meet standards. These funds could have been used for direct services.


Suggested Challenges

<p><i>Rising Cost of Delivery of Service</i></p> <ul style="list-style-type: none"> • Continuing Needs of Health Care Services <p><i>PL 93-638 Issues</i></p> <ul style="list-style-type: none"> • Stakeholders need to be educated • Ownership of “638” needs to be clarified • Seeking Navajo Contract Support Cost <p><i>Working Together</i></p> <ul style="list-style-type: none"> • More Navajos moving off the Reservation • Accountability between the Navajo Tribe and IHS • Changing Leadership • Lobbying Strategies • Caring for our Elders <p><i>Facilities and Construction</i></p> <ul style="list-style-type: none"> • More funds needed for Construction/Renovation Projects • PL 86-121 Projects • Kayenta Health Center • Red Mesa Health Center • Pueblo Pintado Health Center • Gallup Indian Medical Center • Dilkon Health Center 	<p><i>Funding Level</i></p> <ul style="list-style-type: none"> • Not meeting Inflationary costs associated with providing health care • Shortage of Professional, Technical, and Managerial Staff • Review and upgrade salary schedule to Professional staff • Seeking Alternative Resources due to decrease funding • Insufficient resources for Health care Construction • Federal Regulations and Restrictions <p><i>Human Resources Management</i></p> <ul style="list-style-type: none"> • Staffing Shortage • Recruitment and Retention • Data Evaluation • Develop Internal Manpower - Health Professionals <p><i>Technology</i></p> <ul style="list-style-type: none"> • Data/Evaluation • Support for Information Technology Program • Cluster Technology <p><i>Diseases</i></p> <ul style="list-style-type: none"> • Syphilis outbreak • Sexually Transmitted Disease • West Nile Virus
--	---

What are the major successes you have experience?

Through the efforts of the Navajo Area Indian Health Service and the Navajo Nation Division of Health, the following programs and projects are illustrative of some of the successes made in meeting the goals of improving health care and reducing the healthcare disparities faced by the Navajo people.

Major Successes



Functional Services

- Alcohol/Substance Abuse Programs
- Improved Efficiency to Capture Third Party Revenues

Facilities and Construction

- Montezuma Creek, Utah Clinic
- New Navajo Mountain Clinic
- New Fort Defiance Indian Hospital
- Successful in seeking funds
- \$2.4 Million renovation of the Department of Behavioral Services facility in Shiprock, New Mexico

Preventive Health

- Community Health Based Prevention Programs
- Involvement in Behavioral/Lifestyle Changes
- Diabetes Funded Programs
- Diabetes Wellness Centers

Contracts

- Successfully transferring two IHS Programs to PL 93 638 status
- Negotiation with outside funding sources

Information Technology

- Infrastructure and capacity building
- New ADP Equipment


Definition of Direct Service Tribe

Those Indian Tribes who continue to rely on and require the Indian Health Service to deliver health care services as intended by the treaties between the Indian Tribes and the United States Government. Accordingly, the Direct Service Tribes must have greater roles and responsibilities in the planning, administration, and operation of the Indian Health Service program.

Health Priorities of Navajo Nation

The Intergovernmental Relations Committee of the Navajo Nation Council approved via IGRAP-62-04 the joint recommendations of the Navajo Nation and the Navajo Area Indian Health Service on the Healthcare Priority list for fiscal year 2006. The Healthcare priorities were as follows:

1. Health Care Facility Construction
2. Water and Sanitation Projects (PL 86-121)
3. Diabetes
4. Cancer
5. Behavioral Health Services

- 
6. Injury Prevention and Contract Health Services
 7. Dental
 8. Communicable/Infectious Diseases
 9. Heart Disease
 10. Elder Care
 11. Tele-Medicine/Tele-Health
 12. Maternal Child Health

Further, the Navajo Nation and NAIHS continue to work in partnership on the existing and emerging healthcare issues such as:

Medicaid-related Issues:

The Navajo Nation is faced with a unique challenge of dealing with three separate States and three Federal Regional Offices (Region VI, VIII and IX). Currently, over 40 states are faced with severe budget deficits and this has a direct adverse impact on IHS and Indian tribes, including Navajo. For example, one state is faced with around \$40 million Medicaid budget reduction and one of its corrective actions was to reduce eligibility of re-certification from 12-month to 6-month.

Medicare Modernization Act of 2003:

The Medicare Modernization Act of 2003 is being implemented nationwide but more work has to be done to adequately implement various provisions of the MMA as it directly impacts our Indian elders. The Center for Medicaid and Medicare Services (CMS) must work in close partnership with the IHS Area offices and respective Indian Tribes on the education and outreach activities.

Healthcare/Behavioral Health Facilities:

- As American Indians and Alaska Natives assume additional services from the IHS, the funding for facility renovation/construction is absent.
- Tribal programs are then forced to operate out of dilapidated facilities and abandoned “hand-me-down” IHS facilities.

Reauthorization of the Indian Health Care Improvement Act, P.L. 94-437:

- Senate and House bills have been introduced in the 106th, 107th and now in the 108th Congress.
- The Navajo Nation Area workgroup adamantly supports the reauthorization of PL 94-437.



Oklahoma Caucus Report



Oklahoma Area Caucus Notes

The Future of Direct Service Tribes

The Direct Service Tribes (DST) generally feels that they need to have a stronger voice within the I/T/U system. These Sovereign Nations have depended upon the Area Directors and Service Unit Directors to insure equitable resources are budgeted and shared within the I/T/U Health Delivery System. They also intend to educate Congress and the White House about the staggering lack of resources for direct patient care, contract health care and to replace aging facilities within the Oklahoma Area IHS. The Oklahoma Area DST intend to weigh in on such issues as:

Necessity of sharing information by OMB during the Budget Passbacks

The inequity of the IHS funding distribution for both direct service care and CHS resources

Passage of the Reauthorization of the IHCA

More effective collaborations between Tribal Service Unit Health Boards and Service Unit leadership


A greater role in decision making during the I/T/U Budget Formulation process

There is also a pressing need to become more educated concerning intricacies of the I/T/U Health Care Delivery System, so we may in turn be more efficient in our education and guidance to the Congress and White House. These desires by the DSAT are based upon the Treaty Obligations by US Government and its resulting commitment for health care for ALL Indian People, as our theme so adequately expresses the message, "As long as the grass grows and the rivers flow."

Future Goals of the Oklahoma Area Over the Next Year

- Provide comprehensive briefing on the Budget process to the Oklahoma Area I/T/U to facilitate a strategic information sharing with Congress and the White House in order to increase funding for the I/T/U
- Form a workgroup to research the funding disparities within the IHS budget allocation and to address CHS policy issues
- Provide a briefing to the I/T/U on the current status of the Reauthorization of the IHCA
- Insure maximum participation of the Service Unit Health Boards in relation within the Budget Formulation Process
- Provide a cohesive planning effort for the I/T/U and a sharing of "Best Practices"

Major Challenges of the Oklahoma Area Over the Next Year



Unification of the DST in order to insure more parity of resources within the I/T/U budget process

The determination of the message we wish to send as 'One Voice' to Congress and the White House

More efficient management of the CHS program to increase existing resources in order to justify additional CHS resources

The inclusion of all I/T/U health professionals in the quest to maximize resources for the Area

The Major Successes the Oklahoma Area May Experience

By addressing the major challenges put forth by the DST, the Oklahoma Area should expect to be able to:

- Participate more effectively within the I/T/U Budget Formulation Process
- Speak with one voice to Congress and the White House to overcome funding disparities
- Better justify additional resources for direct patient care services, CHS and facilities
- Achievement of more understanding of the intricacies and impacts of the IHS Budget and allocation processes

Sessions that Were of Particular Importance

Each session was thoughtfully planned and each had a particular importance.

However, at our next gathering there needs to be more time allotted for dialogue with participants and the panelists


Given that this was the 1st Annual gathering of the DST, the Oklahoma Area tribes wish to commend the planning committee and facilitators for a job well done

Definition of Direct Service Tribes

Direct Service Tribes are federally recognized tribes who have exercised their option under PL 93-638, Indian Self Determination Act, to require the Indian Health Service to continue to provide direct care, contract health care and environmental health services to all AI/AN within the tribal health care delivery system.

Next Year Conference Development

- Next year's conference should be in Washington, DC, to facilitate a powerful agenda of Washington DC decision-makers from Congress, the White House and federal agencies and programs

- 
- The timing of the DST conference will need to be structured to allow educational visits to the Hill and other offices
 - Tracks should be a product of the Planning Committee, but participant dialogue should be factored into our next gather



Phoenix Area Caucus Report





Update on Comprehensive Strategic Health Planning for the Phoenix Area Indian Health Service

July 7, 2004

Background

In March 1999 in conjunction with the Southwest Indian Health Care Improvement Act Reauthorization consultation, a Phoenix Area Caucus session was held to discuss tribal health concerns. Some of the tribal representatives asked Phoenix Indian Medical Center (PIMC) staff to respond to these concerns. There was a discussion on Indian health plans for the future service delivery and construction needs in the Phoenix Area and how PIMC should respond to meet these needs. The issue of PIMC governance in relation to tribal governments and future recommendations for tribal involvement in planning were also discussed.

In October 1999 at a meeting of Tribal Health Steering Committee and tribal health directors in the Phoenix Area, PIMC renovation was an agenda topic. Tribal leaders recommended that there should be a more cohesive approach between PIMC strategic planning and health care delivery planning and facility construction plans for the whole Area.

ITCA submitted a letter to Don Davis, Area Director of the Phoenix Area IHS (PAO) on February 9, 2000 to formally request support for an area wide tribal health systems strategic health planning initiative. ITCA proposed the establishment of an area wide Strategic Health Planning Working Group to provide advisement and direction to the involvement of tribal governments in health system planning.


PAO responded to the request and funded the project in September 2000.

Tribally Directed Strategic Health Planning Process

The Comprehensive Regional Health System Strategic Planning Project for the Phoenix Area Indian Health Service was established. The objective was to provide a consultative and participatory process for Tribal governments to identify facility and service delivery options needed for American Indians served by IHS and tribal health care programs in the Phoenix Area. The planning process was facilitated with the assistance of Joann Kauffman of Kauffman & Associates, Inc. (KAI). Tribes identified and prioritized their needs by participating in focus group sessions and working group meetings on strategic planning. These were held from October 2000 thru March 30, 2004.

Through the planning process, which included tribal focus group sessions, the document, "Phoenix Area Comprehensive Regional Health Care Strategic Plan" was finalized. Tribal leaders approved it on March 22, 2001. PAO later contracted with the Innova Group to 'quantify' the healthcare needs in the Strategic Plan. Innova Group consultants also participated in the tribal Working Group meetings and conducted local site visits. The tribal and urban participants identified their health priorities and projected resources, staff and facility space needs for 2010. The analysis was conducted and the final draft Master Plan for Phoenix Area Indian Health Services that describes an "Integrated Service Delivery Network," was worked on. The "Phoenix Area Health Services Master Plan was later accepted by the Phoenix Area tribal leaders on November 22, 2002.

The Master Plan consists of a number of sections, which detail the various community-specific needs for each site. Each community profile describes the community, its current services, needed services, including increased funding and staffing, and identifies if other medical centers



are being utilized. The Phoenix Indian Medical Center system is one component of the entire Master Plan and was identified as:

- a medical center providing inpatient and outpatient services
- a resource for specialty care services at rural locations in the 3 State region
- a center for telehealth technology,
- a coordination point to integrate MIS, patient data, and patient care coordination.

Tribal Implementation Planning


In order to complete 'phase three' of strategic planning - to develop tribally directed implementation strategies for the Master Plan- meetings with tribal representatives on the development of an 'Implementation Plan' were conducted. The meetings with Tribal Leaders and tribal health directors were held in Phoenix, AZ, (02/04/04), Reno, NV, (02/17/04), and Salt Lake City, UT, (02/18/04).

During the meetings Tribes received a briefing on the Master Plan and were asked to examine their specific sections. The process involved reviewing the tribal priorities and assessing the services and resources that currently exist and the type of assistance desired in the future to address their needs. The tribal representatives then began the process of describing the steps that would be required to establish the identified services. Several Tribes indicated the need to update the priorities. Also in the meetings a presentation was provided by the Phoenix Area staff on facilities renovation and construction projects underway or being planned. There was also a discussion on alternative (other than IHS) resource options to consider, such as, coordination among multiple communities, grants and partnering with nearby facilities. A timeline from 2004 until 2008 was developed by KAI to assist Tribes in visualizing how their goals for each need would be implemented and met.

Some of the implementation issues raised by the tribal participants included:

- Status of the PIMC Program Justification Document (PJD) and the concern about services that PIMC would provide for Tribes outside of metropolitan Phoenix, Arizona.
- The need for PAO to develop a resource package that identifies the budgetary costs associated with implementing the Master Plan at PIMC, PAO, local Service Units, Tribes and urban Indian health programs.
- The need for PAO to explain how IHS program, service delivery and facility planning link to tribal needs and priorities identified in the Master Plan.
- It was also noted that data from all 39 Tribes was analyzed and incorporated in the Master Plan, but several Tribes did not get included in the assessment conducted by the Innova Group and therefore did not identify their tribal health priorities. Tribes requested that the information from these Tribes (approximately 9) and the urban locations at Salt Lake City and Reno be studied and included in the Master Plan immediately.
- Similarly, other Tribes requested that their community profiles be updated to reflect changes that have occurred in their profile since publishing the plan.
- PAO staff at the three tribal meetings made the point that the Master Plan is a "living document," and a strong effort will be made to keep it updated with the latest information.
- Tribes in Nevada also recommended that a tribal oversight committee be established and that a feasibility study on the needs of tribal communities in Nevada be funded by PAO.

The fiscal year 2006 Tribal/Urban Indian Budget Formulation Meeting for the PAIHS was held in Las Vegas, Nevada on April 1-2, 2004. Part of the agenda included a presentation on strategic planning. During the meeting, Joann Kauffman of KAI provided an update on development of the tribal Implementation Plan. At this time, information was communicated



that Elvin Willie, Schurz Service Unit CEO, was reassigned temporarily to PAO to work with Tribes to update the Master Plan. Mr. Willie presented his plan to first, conduct site-visits to those Tribes not yet assessed, and then to continue to work to update the plan. Up to this date, he has begun conducting visits and will continue until all Tribes have been visited. Tribes in Nevada requested close communication with Mr. Willie to update their community profiles.

Nevada Statement

During the FY 06 Budget Formulation Meeting, the delegation of Nevada tribal representatives present held a caucus to discuss the Phoenix Area Master Plan, specifically, the Phoenix Indian Medical Center (PIMC). As a result of their discussion, the Nevada delegation developed a Statement for the Record concerning the Phoenix Area Indian Health Service Master Plan. The document stated, in brief, that they could not support the Phoenix Area Master Plan or the PIMC PJD because it does not account for Nevada health care needs.


June 2-3, 2004 Dr. Grim Meeting

The Inter Tribal Council of Nevada requested a meeting of the Phoenix Area Tribes with Dr. Grim. It was held at the Point South Mountain Resort in Ahwatukee, Arizona on June 2, 2004 during the National Direct Service Tribes Meeting. A second meeting was called on June 3, 2004. Nevada tribal representatives discussed their concerns relating to the renovation and construction of the new PIMC in relation to the Phoenix Area Health Services Master Plan. They requested that the Phoenix Area support a position to provide more budgetary analysis of Nevada tribal health priorities listed in the Master Plan. Plus individual tribal leaders verbally stated the lack of Nevada Tribes' support for the PIMC expansion "until such time that Nevada health system inadequacies are addressed in the PIMC Program Justification Document." Nevertheless they also stated it was not their intention to oppose needed health care in Arizona, but that there should be equity in improving the overall health care access and health status throughout the Area.

Consideration of Tribal Issues

At the meeting with Dr. Grim, the Tribes asked Dr. Grim to consider the following issues.

- PIMC is # 1 on the IHS new construction list for inpatient hospital facilities. The updated PIMC PJD includes three satellite outpatient clinics, one inpatient facility and expanded regional/area wide services were identified in the Master Plan for inclusion in the PIMC Program Justification Document (PJD). PIMC Renovation and construction is seen as necessary in order to meet the dramatic workload increases since the current facility was planned in the 1960's.
- During the Master Plan process Tribes in the Phoenix Area had indicated their support to "grandfather in" the PIMC renovation/construction project as well as other projects that are moving through the PJD development and approval process. Tribes noted that without an organized and collaborative effort to support funding for PIMC, Congressional members in Washington, D.C. would not be inclined to support it.
- Tribes in Nevada have indicated their difficulty in supporting the PIMC PJD. Some discussion at Area tribal meetings was focused on how to reallocate funds considered for PIMC or strategies to utilize PIMC earmarks to design services for Nevada Tribes. Tribes in Nevada strongly advocate health system improvements that can expand tribal and IHS clinically based services and contract health care services. There are no IHS inpatient facilities located in Nevada. It is clear that several Tribes in Nevada or Utah do not presently or in the future foresee extensive utilization of the Medical Center and



prefer to garner inpatient services at nearby hospitals that must be paid through Contract Health Care contracts or alternate resources.

- Tribes in the three States agree that full funding is needed for the Phoenix Area Master Plan in order to correct the deficiencies quantified in the Master Plan by 2010. These include:
 - insufficient Contract Health Service funding, only 30% of the necessary CHS funds are appropriated
 - only 45% of the necessary space currently exists, 1.3 million square feet will need to be added to the delivery system

Full funding of the Master Plan is a top priority for Phoenix Area Tribes, but a separate resource package has not yet been developed. Tribes requested PAO assistance to calculate costs for the total package described in the Phoenix Area Master Plan

- All Tribes need to have a solid understanding of the Master Plan so they can have mutually supportive advocacy efforts.
- It would be beneficial for the Phoenix Area to respond and develop strategies to implement the Master Plan to address the needs and concerns of the Area as a whole.
 - PAO should communicate how they will proceed in the forward movement of strategic planning.
- PAO should also develop a mechanism for ongoing and consistent communication between the Tribes and the Phoenix Area Office in the continued effort to keep the Master Plan a “living” document. More recently Sandra Pattea, RN, was hired as the Integrated Service Delivery Network (ISDN) Coordinator at the Phoenix Area Indian Health Service and her role with regard to Master Plan implementation is being defined.
- All tribal leadership in the Phoenix Area require a comprehensive understanding of the Master Plan, the PIMC PJD and other PJD’s going forward that will fold in all elements of the Master Plan



Portland Area Caucus Report





Portland Area Caucus

Direct Service Tribes Annual Meeting Portland Area Caucus

1. The Future of Direct Service Tribes

a. What are the future goals of your Area over the next year?

- Empowerment of tribal members through education to maximize effectiveness of existing health care dollars. (Taking responsibility for health prevention; IHS has built a system of dependency, need to change this by providing education about health promotion; Utilize wait times in facilities to provide this).
- Establish an Office of Direct Service Tribes within the immediate office of the IHS Director.
- Conduct an evaluation of diminished services experience by Direct Service Tribes resulting from Self-Governance and a plan to restore those services.
- Budgetary concerns and need for more funding.
- Identify Best Practices of Direct Service Tribes and share for replication
- Develop standing committee with Area Health Board (NPAIHB)
- Consider restructuring Area Health Board (NPAIHB) votes based on user population/tribal enrollment.
- Conduct DST meetings in conjunction with quarterly Area Health Board meetings.
- Unity of lobbying efforts amongst DST. Need to think more strategically, be able to document needs with data, and change rhetoric regionally. (White papers, DST advocacy plan)
- Health Priorities: diabetes, obesity, heart disease, cancer (men & women), CHS dependent.

b. What are the major challenges you may experience over the next year?

- The Indian vote and coalition building: educate about importance of the Indian vote, develop alliances, PAC strategies -- Many swing states include significant Indian populations and we really can influence elections.
- Reauthorization of the Indian Health Care Improvement Act.
- Medicare/Medicaid Issues: countering recent ruling of CMS on Medicaid and Civil Rights issues related to AI/AN participation in State Medicaid programs.
- Educating our population about alternate resource requirements.
- Educating our legislators and staff at all levels (local, state, and federal) about the health care needs of DSTs.
- Educating our tribal leaders, and council members that turn-over about health issues



- Recruitment of health care professionals.
 - Seek funding based on workload versus user-population and eligibility issues.
 - Information technology and need for data
 - Tribal specific issues such as: mental health, dental, substance abuse and alcohol counseling.
 - Pharmaceutical costs
- c. What are the major successes you may experience?
- IHS sponsored DST First Annual Conference and commitment for future years.
 - Development of Electronic Health Record being beta tested at several DST sites.
 - Construction of small clinic at White Swan.
 - Portland Area ability to be bi-partisan with contracting and compacting Tribes.
 - We have the best IHS Budget Analysis and Recommendations report.
 - Model Programs that are emulated throughout Indian Country: (NW Epi-Center Project; Diabetes Data Project; State/Tribal relationships)
 - Proactive Area Health Board that works on behalf of all 43 NW Tribes in the areas of health policy, budget, and legislative issues: (i.e. Reauthorization of IHCIA; Establishment of CMS TTAG; and IHS budget and appropriations process)
- d. Was there a session of particular use and help?
- Not prepared to answer until hearing all presentations.
2. Determine the definition of who we are as Direct Service Tribes
- This is difficult to do because many tribal health programs are hybrid systems.
 - Designation of health care delivery type is determination of the individual tribes.
3. Next Year's Conference Development
- Theme: "Collaboration of DST, Self-Governance, and Urban programs.
 - Education about the needs of health care in Indian Country to those who need it.
 - The need for holistic approaches to health care that include Spiritual/Mental/Physical well-being (Expressed by Dr. Grim)
 - The need of IHS professionals listening to the "Culture" of the people they serve (Chairman Howell/Pawnee Nation).



Tucson Area Caucus Report (Unavailable at the time of print)





Evaluations and Participant Comments



Evaluations of Panel Sessions


Panel I: Federal Perspectives on the Budget Process

Total # of Evaluations: 105

Overall Quality of Session	3.923
Organization of Session	3.5
Ease of Registration	3.808
Quality of Presenters	4.115
Opportunity to Interact with Presenters	2.8
Quality of Handouts	2.423
Facility, Refreshments	4

Comments:

1. Need to keep presenters on time schedule.
2. Presenters need to know their topic.
3. Being not able to ask questions was not beneficial.
4. Rhetoric was not beneficial.
5. **In the future**, please address CHS and Partnering.
6. Overview of Budget Formulation was beneficial.
7. **In the future**, spend more time on the specifics of budget planning and process.
8. Excellent session, need more time to interact.
9. Learning how to Lobby was beneficial.
10. **In the future**, please address consortium: All tribes to Lobby for one budget.
11. Facilitator needs to keep speakers on time.
12. Nick Burbank was fairly helpful.
13. All speakers echoing the same ideas are not beneficial.
14. Too many presenters, not enough time.
15. Great start for first Annual Conference.
16. Set room classroom style, not theatre for better note taking.
17. Need more Hill staff at next meeting.
18. **In the future**, please address Authorizers and Appropriators for budget process.
19. Dr. Rhoades perspective was great. He should have been at opening session to set tone.
20. Too long, too much sitting and listening without interaction or participation.
21. Please provide more formats/more diversity – panels overworked and redundant.
22. Too many speakers for one day, too many speakers ignoring time frame.
23. Over ambitious agenda was distracting.
24. The conference was beneficial, no bad aspects.
25. Schedule future conferences around Tribal Council sessions to ensure proper Tribal leader participation.
26. Dr Grim was the most beneficial aspect of this session.
27. Presenters need to talk positively, do not bring politics into speech.
28. **In the future**, break out into workshops.
29. Amadeo Shije did a great job as facilitator.
30. Registrars need to greet and give attendees information with a smile.

- 
31. Facility was too cold.
 32. **In the future**, please address Navajo Area, 638 Sites (Winslow and Tuba City) should be invited.
 33. Facility was too large.
 34. Mr. Burbank, Mr. Montgomery and Ms. Brokenrope did excellent presentations.
 35. Ms. Tracy did not provide information.
 36. Set chairs in three sections (better yet 4) rather than two.
 37. Ms. Brokenrope to do entire session alone as teaching tool.
 38. Dr. Rhoades and Mr. Roach should have entire half day to instruct.
 39. Have 2nd Annual Conference at Mystic Lake, outside the Twin Cities.
 40. Alida Montiel and C. Montgomery were very beneficial.
 41. In the future: thinking strategy for changing Budget Formulation process to be more effective. We got info on what it is, how it works but nothing on strategy.


Panel I, Part II: Tribal Perspectives on the Budget Process

Total # of Evaluations: 95

Overall Quality of Session	3.63
Organization of Session	3.44
Ease of Registration	3.29
Quality of Presenters	4.05
Opportunity to Interact with Presenters	2.66
Quality of Handouts	2.63
Facility, Refreshments	3.77

Comments:

1. All presenters and information was excellent.
2. Federal perspective on the budget process was beneficial.
3. In the future: Continuous educating Tribal and Federal representatives.
4. Alida Montiel and Ed Fox were beneficial.
5. Assertions by Dr. Rhoades were based on faulty logic and not a true indication of what is going on in Indian health.
6. In the future: Budget strategies and brainstorming to get more dollars. Not presentations but a working session.
7. Rachel Joseph was beneficial.
8. In the future: More information on 437.
9. It has been a very informative conference.
10. Need timekeeper to keep speakers on track.
11. Area Tribal leader comments were NOT beneficial.
12. Need more Tribal perspectives. (Same person as #11)
13. Dr. Grim was beneficial.
14. In the future: More from Dr. Rhoades and Ed Fox; more participation.
15. Facilitator needs to keep speakers on time.
16. Thanks to the Tribes for sponsoring the breaks!
17. Turn off cell phones!!

- 
18. In the future: Medicare and Medicaid, Breakout sessions, interaction with presenters.
 19. Keep bios to a minimum.
 20. Great organization and logistics of the conference: agenda, location, and set-up.
 21. Agenda too lengthy.
 22. Tribal leader health priorities were beneficial.
 23. Use more visual aids, power points, etc.
 24. One voice and bringing the people together as on voice/concern was beneficial.
 25. In the future: Training and hints for Lobbying and strategies.
 26. Rachel Joseph did a great job.
 27. In the future: Strategic planning of recommendations; best practices. Focus on overall goals and theme.
 28. Tribe's handout on Historical Perspectives, a discussion paper was beneficial.
 29. In the future: How to use Tribal Priority Allocations.
 30. EXCELLENT CONFERENCE!
 31. All sessions are beneficial.
 32. In the future: Meth addiction and the effects on funding. Treatments costs and reality.
 33. More fruit next year please.
 34. In the future: More interaction with panel.

Panel II: Regional Directors Panel

Total # of Evaluations: 1

Overall Quality of Session	4
Organization of Session	4
Ease of Registration	4
Quality of Presenters	4
Opportunity to Interact with Presenters	4
Quality of Handouts	3
Facility, Refreshments	4


Panel III: Upholding the Federal Responsibility

Total # of Evaluations: 64

Overall Quality of Session	3.759
Organization of Session	3.759
Ease of Registration	3.759
Quality of Presenters	3.793
Opportunity to Interact with Presenters	2.552
Quality of Handouts	2.241
Facility, Refreshments	3.69

Comments:

1. Michael Hughes presentation was beneficial.
2. Presenters need to know their topics.

- 
3. In the future: How can we have our voice heard? Our Area Director is “pro self-governance and pro contracting.” How do we get the Area’s to allow local health priorities to be implemented? They have a different agenda. How do we recover the lost services that were given up in the “Shares”?
 4. June is too hot for Phoenix.
 5. The Congressional actions on the budget were beneficial.
 6. Congressional statements were NOT beneficial.
 7. In the future: Cohesive movement for the future.
 8. Mr. Hughes was outstanding!
 9. Too much Navajo on panel, bring other tribes for input.
 10. In the future: Economic development, strategies and more time for speakers.
 11. Presenters and facilitators are excellent.
 12. Last minute cancellations are not good.
 13. The planning committee has done a great job, don’t change anything.
 14. Have next meeting at a tribal owned complex.
 15. Speakers countering some “incorrect” statements made the previous day were beneficial.
 16. Concept of panel and history of tribes brought forth by panelist was beneficial.
 17. In the future: Unified strategy, resolutions or position papers, action plans, involve Native Hawaiians and Mexicans, they are brothers and sisters too. Invite staffers and have quarterly meetings.
 18. Facilitator let attendee comments get out of control.
 19. No time to enjoy the facility.
 20. In the future: Once we have the info, how do we put it into action?
 21. June Tracy and Michael Hughes gave outstanding presentations.
 22. Some presenters/presentations were not beneficial.
 23. Need to coordinate power point presentations with speeches, USE TECHNOLOGY!
 24. Self-Governance focus on contracting related bills (House and Senate) was NOT useful.
 25. Congressional video announcements were beneficial.
 26. In the future: More Michael Hughes, budget and grant processes, health care recruitment.
 27. Rhetoric was NOT beneficial.


Panel IV: Building Opportunities, Networks and Partnerships: “Expanding the Relationship”

Total # of Evaluations: 36

Overall Quality of Session	4.05
Organization of Session	3.85
Ease of Registration	2.7
Quality of Presenters	4.25
Opportunity to Interact with Presenters	2.65
Quality of Handouts	2.3
Facility, Refreshments	3.35

Comments:

1. Dr. Annette and Barbara Sabol were beneficial.
2. In the future: More from Kellogg and other foundations. (New cereals available?)

- 
3. In the future: More creative ways to network and build relationships.
 4. Best practices were beneficial.
 5. Please control time allocation to presenters. I've waited to hear Dr. Grim. Please be mindful that some participants have flights to catch. Give ample time to Dr. Grim, he has an important message to share.
 6. CMS and Kathy Annette were both beneficial.
 7. In the future: Best practices, Partnerships and collaborations, leadership development,
 8. In the future: Local events, casinos etc.; also define who should attend.
 9. The SAMHSA speaker spoke to fast.
 10. Hilda Moss is a great facilitator.

Panel V: Indian Health Appropriations: Entitlement vs. Discretionary

Total # of Evaluations: 43

Overall Quality of Session	3.72
Organization of Session	3.32
Ease of Registration	2.96
Quality of Presenters	3.88
Opportunity to Interact with Presenters	2.6
Quality of Handouts	2.48
Facility, Refreshments	3.52

Comments:

State level Lobbying was beneficial.

We had to sit too long.

In the future: Partnerships, development with schools.

Dr. Grim's presence during the entire conference was beneficial. He demonstrated quality patience and kindness. A true gentleman to listen to our recommendations to improve Indian health disparities.

Regional Directors need accountability. Spent money to have them at the meeting but they got off easy. Invite back next year. Native Hawaiians have concerns too.

In the future: Regional Directors, have technical assistance work sessions.

NO MORE INDIAN TIME!

Turn off cell phones.

Senator Hale was NOT beneficial.

Albert Hale was beneficial.

The sessions on health care are having a negative effect on my health. The day is too long to sit from 830-530 or longer. Should have next conference at an Indian owned facility.

Panelist did not show, was NOT beneficial.

Need breakout sessions, too much sitting.

Don't give politicians the platform.

Too many topics.

Speakers did not talk about the future of health care delivery.



Panel VI: Documenting the Need

Total # of Evaluations: 20

Overall Quality of Session	4.24
Organization of Session	3.94
Ease of Registration	3.35
Quality of Presenters	4.41
Opportunity to Interact with Presenters	3.35
Quality of Handouts	2.94
Facility, Refreshments	3.76

Comments:

1. The different views from speakers were beneficial.
2. Hard to absorb info without handouts.
3. In the future: Data trends, data sharing, and agreements.
4. Some redundancy with speakers.
5. In the future: The responsibility of Indian leaders to encourage their Tribal populations to be self-determined, i.e. healthy lifestyles.
6. Jerry Freddie, Clayton Small, Kathy Annette and the Kellogg foundation were VERY beneficial.
7. In the future: Feature updates on various software packages. How is data shared?
8. IN the future: Meth addiction
9. Many thanks to the planning committee for making this conference a reality.



Conference Attendees List







CONFERENCE ATTENDEES

Direct Service Committee Members

Aberdeen Area	Carole Anne	Heart
Aberdeen Area (Alt.)	John	Blackhawk
Albuquerque Area (Alt.)	Ken	Lucero
Albuquerque Area	Amadeo	Shije
Bemidji Area (Alt.)	Luke	Willson
Billings Area (Alt.)	Fred	Guardipee
Billings Area	Hilda	Moss
Navajo Area (Alt.)	Alice	Benally
Navajo Area	Evelyn	Acothley
Oklahoma Area	George	Howell
Oklahoma Area (Alt.)	Wallace	Coffey
Phoenix Area (Alt.)	Daniel	Eddy, Jr.
Phoenix Area	Jody A.	Abe
Portland Area	Garland	Brunoe
Portland Area (Alt.)	Mathew	Tomoskin
Tucson Area (Alt.)	Rosemary	Lopez
Tucson Area	Rueben	Howard

Indian Health Head Quarters

Technical Advisors

Associate Director, Tribal Activities	Douglas	Black
Staff Specialist to the Director	Stacey	Ecoffey
Aberdeen Area IHS	Rick	Sorensen
Albuquerque Area IHS	Johnnita	Townsend
Navajo Area IHS	Randall	Morgan
Phoenix Area HIS	Michael	Joseph
Bemidji Area IHS	Charlene	Redthunder
Albuquerque Area IHS	Anthony	Yepa

Support Staff

Program Analyst	Sharon	Folgar
Program Analyst	Felicia	Roach

National Indian Health Board (Conference Coordination)

Francilla	Whiteskunk	Director of Operations
Jay	Grimm	Director of Special Projects
Vincent	LaFronza	Senior Kellogg Fellow
Holly	Grimm	I T Consultant

Conference Registered Participants

Evelyn J.	Acothley	Navajo Nation
Myrtle	Adams	Confederated Tribes of Warm Springs
Florence	Albert	Hopi Tribe
Reanna	Albert	Hopi Tribe
Jack	Allen	Centers for Medicare and Medicaid Serv
Kathleen	Annette, MD	Indian Health Service
Rod	Ariwite	Pueblo of Laguna
William	Axlund	IHS – Aberdeen



Gwendolyn	Bahe	Fort McDowell Yaupai Nation
Glenda	Baker-Embry	Mandan, Hidatsa, & Arikara Nation
Keith	Barrick	IHS - Cherokee - W.W. Hospital
Charles	Bearcomesout	Northern Cheyenne Tribe
George	Bearpaw	IHS - Tucson Area Office
Cheryl	Begay	Native American Community Health Ctr
Daryl	Begay	Holland & Knight
Mae-Gilene	Begay	Navajo Division of Health
Paul M.	Begay	IHS - Chinle Service Unit
Nella	Ben	IHS - San Carlos
Alice W.	Benally	Navajo Nation
Lena	Benally	IHS - Phoenix Area
Rosita	Beno	Navajo/NDOH-Health Education Program
Vincent	Berkley	IHS - Phoenix Area
Ella	Bia	Native American Community Health Ctr
Kenn	Bisonette	Northern Cheyenne Tribe
Douglas	Black	IHS – Rockville
Millie	Blackmon	IHS - Clinton Indian Hospital
Elizabeth	Blackowl	Pawnee Nation of Oklahoma
Harlene A.	Blue	Red Lake Band of Chippewa Indians
Rob	Blue	Red Lake Band of Chippewa Indians
Helen	Bonnaha	IHS - Kayenta Health Center,
Elliott L.	Booth	Colorado River Indian Tribes
Andrea	Bowen	Pawnee Nation of Oklahoma
Bea	Bowman	Phoenix Indian Medical Center
Richard	Bowman	IHS - Gallup Medical Center
Tommy	Bowman	IHS - Dallas Engineering Services
Gary	Breshears	IHS - Phoenix Area
Frieda	Breum	Winnebago Tribe of Nebraska
Bob	Brisbois	Northwest Portland Area Indian Hlth Bd
Mary	Britan	Central Oklahoma Amer. Ind. Health Council
Eric	Broderick	HHS – IGA
Eddie	Brokesoulder	Otoe-Missouria Tribe
Bill	Brooks	Centers for Medicare and Medicaid Serv
Garland	Brunoe	Confederated Tribes of Warm Springs
Milo	Buffalo, Jr.	Sac and Fox Tribe
Robyn	Burdette	Summit Lake Paiute Tribe
Julia	Burnette	White Mountain Apache
Mary Jo	Butterfield	Makah Tribal Council
Karen	Camilli	IHS - Elko Service Unit
Lillian	Celaya	San Lucy District
Steven	Cesspooch	Ute Indian Tribe
Roselyn	Chapela	Navajo - Health Education Program
Geneva M.	Charley	Confederated Tribes of Warm Springs
Cliff	Chasing Hawk	Rosebud Sioux Tribe
Lorena	Childs	San Lucy District
Cynthia	Claus	Mayo Clinic Cancer Center
Janice	Clements	Confederated Tribes of Warm Springs
Joann	Comer	Iowa Tribe of Kansas & Nebraska
Pam	Conley	IHS - Phoenix Area



James	Constance	Phoenix Indian Medical Center
Pete	Conway	IHS - Billings Area
Thornton	Coochyanma	Colorado River Indian Tribes
Rufus	Cox	Central Oklahoma Amer. Ind. Health Council
Lillie	Cummings	Pawnee Nation of Oklahoma
Larry	Curley	Fallon Paiute Shoshone Tribe
James	Cussen	IHS - Phoenix Area
Tony	Danielson	HIS
Donna	Dante	Native American Community Health Ctr
John	Daugherty	IHS - Oklahoma City Area
Don J.	Davis	IHS - Phoenix Area
Nancy	Davis	IHS – Aberdeen
A. Diane	Daychild	Native American Community Health Ctr
Willis	Daychild	IHS - Phoenix Area
Frank	Dayish	Navajo Division of Health
Terry	Dean	IHS - Portland Area
Bernard	DeAsis	IHS - Tucson Area Office
Victor	Dee	Utah Navajo Health System
Ronald	Demaray	IHS – Rockville
Eleanor	Dementi	Copper River Native Asso.
Louis	DeRain	Iowa Tribe of Kansas & Nebraska
Mike	Deswood	IHS - Chinle Service Unit
Dinah	Donley	Osage Tribe of Indians
Mark	Downing	IHS - Phoenix Area
Mike	Durkin	IHS – Rockville
Kathryn	Eagle, MD	White Mountain Apache
Paul J.	Ebbert	Ute Indian Tribe
Phyllis	Eddy	Indian Health Service
Daniel	Eddy, Jr	IHS - Phoenix Area
Lorraine	Eiler	San Lucy District
Bill	Elliott	Fallon Paiute Shoshone Tribe
Marlene	Enacko-Yazzie	Navajo Nation
Deanna	Etnire	Hopi Tribe
Naomi	Evanishyn	Salt River Pima-Maricopa Indian Comm 3
Leah	Exendine	Washoe Tribal Health Clinic
Adlai	Falls Down	IHS - Billings Area
John	Farris, MD	IHS - Cherokee - W.W. Hospital
Mary	Felter	Hopi Tribe
Julie	Ferrara	Pharmacy Care Alliance
Anita	Fields	IHS – Rockville
Alberta	Fisher	Northern Cheyenne Tribe
Lori	Fitzpatrick	Trenton Indian Service Area
Sharon	Folger	IHS – Rockville
Ed	Fox	Northwest Portland Area Indian Hlth Bd
Charlotte R.	Francis	Navajo - Health Education Program
Jerry	Freddie	Navajo Nation
Suan	Fredericks	IHS – Billing
Susan	Fredericks	IHS - Billings Area
Franklin R.	Freeland	IHS - Fort Defiance
Christine	Freeman	Northern Cheyenne Tribe



Theresa	Galvan	Navajo Division of Health
Violet	Garcia	Jicarilla Apache Nation
Rod	Gardner	IHS - Sells Service Unit
James	Garvie	IHS – Rockville
Patricia	Gloshay	White Mountain Apache
Robyn	Good Luck	Crow Tribe
Raymond	Grandbois	IHS – Aberdeen
Denise	Grenier	IHS - Albuquerque Area
Dr. Roger	Griggs	White Mountain Apache
Dr. Charles	Grim	IHS - Rockville
Fred	Guardipee, Sr.	Blackfeet Tribe
Mary L.	Guardipee	Indian Health Service
Deborah	Hall-Thompson	Mandan, Hidatsa, & Arikara Nation
Charlene	Hamilton	IHS - Whiteriver Hospital
Lori	Hamilton	Chickasaw Nation
Allan	Harder	Oklahoma City Area Inter-Tribal H. Bd
Dawna	Hare	Pawnee Nation of Oklahoma
Marc	Harrison	Native American Community Health Ctr
Gary	Hartz	Indian Health Service
Lillie	Haskie	IHS - Chinle Service Unit
Keller	Hayes	Diversity of Leadership Coaching
Howard	Hays, MD	IHS - Albuquerque Area
Rosanne	Headswift	Northern Cheyenne Tribe
Delvis	Health, Sr.	Confederated Tribes of Warm Springs
Karen	Heath, MD	IHS - San Carlos
Richard	Heller	IHS - Phoenix Area
Mike	Henry	Santee Sioux Nation
Reuben	Henry	Confederated Tribes of Warm Springs
Jackson	Henry, Sr.	San Carlos Apache Tribe
Richard	Henson	Central Oklahoma Amer. Ind. Health Council
Joseph	Herrera	IHS - Albuquerque Area
Philene	Herrera	Navajo Division of Health
DeAlva	Honahnie	IHS - Phoenix Area
Daniel	Honaliaii	Hopi Tribe
Sharon	Hoppman	IHS – Rockville
Cynthia	Horse Chief	Pawnee Nation of Oklahoma
Lee	Hoss	Flandreau Santee Sioux Tribe
George	Howell	Pawnee Nation of Oklahoma
Geraldine	Howell	Pawnee Nation of Oklahoma
Frederick L.	Hubbard	White Mountain Apache
Harry	Hubbard	Navajo Nation
John	Hubbard, Jr.	IHS - Navajo Area
Barbara	Hudson	Indian Health Service
Dennis	Huff	Native American Community Health Ctr
Emily	Hughes	Norton Sound Health Corporation
Kathy	Hughes	Oneida Tribe
Michael	Hughes	Michael Hughes
Terry	Hunter	Central Oklahoma Amer. Ind. Health Council
Margie	Hutchinson	Confederated Tribes of the Colville Res
Patricia	Ike	Yakama Nation



Shanna	Ioane	Tohono O'Odham
Shawn	Jackson	Northwest Portland Area Indian Hlth Bd
Harley	Janeway	White Mountain Apache
Darrell	Joe	Navajo Division of Health
George R.	Joe	Navajo Division of Health
Casilda	Johnson	Tonto Apache Tribe
Julie	Johnson	MACT Health Board
Roland	Johnson	Pueblo of Laguna
Shirley	Johnson	IHS - Neah Bay Service Unit
Willie	Johnson	Navajo Nation
Roberta	Johnston	Salt River Pima-Maricopa Indian Comm
Raymond	Jones	Crownpoint Healthcare Facility
Michael	Joseph	IHS - Phoenix Area
Andy	Joseph, Jr.	Confederated Tribes of the Colville Res
Wilson	Justin	Mt. Sanford Tribal Consortium
Catherine	Katchia	Confederated Tribes of Warm Springs
Nadine	Kauley	IHS - Tucson Area Office
Dale	Keel	IHS - Oklahoma City Area
Catherine E.	Keene	IHS - Wind River
Rosella	Killsnight	Northern Cheyenne Tribe
John	Kittredge	IHS - Tucson Area Office
Melanie	Knight	Cherokee Nation
Ursula	Knoki-Wilson	IHS - Chinle Service Unit
Lucy	Knorr	Navajo/NDOH-Health Education Program
Michelle	Kopecky	IHS – Aberdeen
Sheila	LaDeaux	Oglala Sioux Tribe Native Women's' Health
Tim	Lamewoman	Northern Cheyenne Tribe
Travis	Lane	Inter Tribal Council of Arizona
Rachel	LaRance	Northern Cheyenne Tribe
Herman	Largo	Navajo Nation DBHS
Becky	Leach	Inter Tribal Council of Arizona
Don	Lee	IHS – Aberdeen
Jackie	Lee	White Mountain Apache
Shannon	Leman	Indian Health Service
Carole	Liggins	Oneida Tribe
Garfield	Little Light	IHS - Billings Area
Donna	Littlewolf	Northern Cheyenne Tribe
Marilyn	Lomakema	IHS - Tucson Area Office
Toni	Loneman	IHS - Tucson Area Office
Keith	Longie	IHS – Rockville
Rosemary	Lopez	Tohono O'Odham-Dept. of Human Services
Dr. Zeenat	Mahal	Inter Tribal Council of Arizona
Michael	Mahsetky	IHS – Rockville
Darlene	Mansfield	Phoenix Indian Medical Center
Albert	Manual, Jr.	San Lucy District
Gail	Martin	IHS – Aberdeen
Tim	Martin	USET Inc.
Blanchard M.	Matte	Makah Tribal Council
Mary Lou	McAlexander	Duckwater Shoshone Tribe
Jon	McArthur	White Earth Health Center




Andrew	McAuliffe	IHS - Schurz Service Unit
Susan	McCraw Helms	Salt River Pima-Maricopa Indian Comm
Wallace	McGilbert	IHS - Navajo Area
Sherilla	McKinley	Salt River Pima-Maricopa Indian Comm
Edwin	McLemore	IHS - Cherokee - W.W. Hospital
Ida	McVicker	IHS - Fort Defiance
Patricia	Medina	Winnebago Tribe of Nebraska
Nelson	Miguel	San Lucy District
Robert	Miller	Confederated Tribes of Warm Springs
Verna	Miller	IHS - Rockville 1
Cynthia	Mills	Yakama Nation
Donna	Mitchell	Yavapai-Prescott Indian Tribe
Violet	Mitchell-Enos	Salt River Pima-Maricopa Indian Comm
Theresa	Moler	Osage Tribe of Indians
Wendy	Montemayor	Oklahoma City Area Inter-Tribal H. Bd
Alida	Montiel	Inter Tribal Council of Arizona
Sherriann	Moore	IHS – Winnebago
Pete	Moore, Jr	Pawnee Nation of Oklahoma
Albert L.	Morgan	Crownpoint Healthcare Facility
Manuel	Morgan	Utah Navajo Health System
Mary Lou	Morgan	Crownpoint Healthcare Facility
Randall	Morgan	IHS - Navajo Area
Christina	Morrow	National Congress of American Indians
Joseph	Moses	Confederated Tribes of Warm Springs
Myron	Moses	San Carlos Apache Tribe
Alvin	Moyle	Fallon Paiute Shoshone Tribe
Anita	Muneta	Crownpoint Healthcare Facility
Walter	Murillo	Native American Community Health Ctr
Trina	Nation	IHS - Wind River
Cynthia	Norris	Tohono O'Odham-Dept. of Human Services
Genevieve (Jenny)	Notah	IHS - Navajo Area
Belle	Nunez	Jicarilla Apache Nation
Oscar	Olnen	Yakama Nation
Amber	Olson	Indian Health Service
Debbie	O'Neal	Duckwater Shoshone Tribe
Debbie	O'Neil	Duckwater Shoshone Tribe
Jean	Othole	IHS – Zuni
Kristy	Park	Office of Management and Budget
Bruce	Parker	IHS - Albuquerque Area
Mitchell	Parks	Salt River Pima-Maricopa Indian Comm
Russ	Pederson	IHS - Albuquerque Area
Merle	Pete	Navajo Nation
Norman J.	Peterson	Inter Tribal Council of Arizona
Tony	Peterson	IHS – Aberdeen
Velda	Piapot	San Carlos Apache Tribe
Wesley	Picciotti	IHS - Phoenix Area
Jose	Pilone, Sr.	San Lucy District
Monica	Pleiman	Optimum Management Systems
Madan	Poudel	Navajo - Health Education Program
Terry	Pourier	Oglala Sioux Tribe 4



Tony	Prairebear	Northern Cheyenne Tribe 1
Robert	Price	IHS - Tucson Area Office
Kurt	Priessman	IHS - Tucson Area Office
Roberta	Queahpema	Confederated Tribes of Warm Springs
Marie	Ramirez	Snoqualmie Tribe
Julie	Rand	CMS New York Regional Officer
Charlene	Redthunder	Indian Health Service
Tamara	Ribas	IHS - Tucson Area Office
Felicia	Roach	IHS – Rockville
Anslem	Roanhorse	Navajo Division of Health
Caleb	Roanhorse	IHS - Fort Defiance
Jim	Roberts	Northwest Portland Area Indian Hlth Bd
Muriel	Rodedeaux	Pawnee Nation of Oklahoma
Albert	Ross, Jr.	IHS - Navajo Area
Beverly	Russell	National Council of Urban Indian Health
Tina	Russell	IHS – Aberdeen
Barbara	Sabol	W. K. Kellogg Foundation
Alvins	Sage, Sr.	Cheyenne/Arapaho Tribes of Oklahoma
Robert	Sakiestewa, Jr.	Hopi Tribe
Michael	Salabiye	Navajo Nation DBHS
Robert	Sam	Summit Lake Paiute Tribe
Carmelita	Sanchez	Zuni Pueblo
Carmelita	Sanchez	Zuni Pueblo
Debra	Sanchez	White Mountain Apache
Dashne	Sandoval	Crownpoint Healthcare Facility
Taylor	Satala	IHS - Tucson Area Office
Robert	Scabby	Salt River Pima-Maricopa Indian Comm 3
Joseph	Serna	Kachina Systems
Dean	Seyler	IHS - Whiteriver Hospital
Amadeo	Shije	All Indian Pueblo Council
Brenda	Shore	USET Inc.
Herman	Shorty	NAVAJO NATION 3
Robert	Shot with two arrow	Rosebud Sioux Tribe
Vaughn	Sieweumptewa	IHS - Hopi Health Care Center
Nettle Grant	Skit	HHSS
Duane	Silk	Standing Rock Sioux Tribe 2
Donna	Singer	Utah Navajo Health System
Gaylord	Siow	Pueblo of Laguna
Carmelita Wagemo	Skeeter	Indian Health Center - Tulsa
Jason	Slater	TISA
Olivia	Sloan	Inter Tribal Council of Arizona
Clayton	Small	IHS - Northern Cheyenne
Terry	Smith	IHS - Portland Area
Stanley	Smith, Jr.	Confederated Tribes of Warm Springs
Dennis	Smith, Sr.	Shoshone-Paiute Tribes of Duck Valley
Rick	Sorensen	IHS – Aberdeen
Donita	Sioux	Northern Cheyenne Tribe 1
Phyllis	Soxie	Pawnee Nation of Oklahoma
Ernestine	Spang	Northern Cheyenne Tribe 1
Wehnora	St. Cyr	Omaha Tribal Council



Mary Lou	Stanton	IHS - Rockville 1
Hickory	Starr, Jr.	Lawton Indian Hospital
John	Stensgar	Confederated Tribes of the Colville Res
Lester	Suneagle	Pawnee Nation of Oklahoma
Ron	Suppah	Confederated Tribes of Warm Springs
Anne	Susan	IHS - Phoenix Area
Max	Tahsuda	IHS - Oklahoma City Area
Thomas	Tahsuda	IHS - Phoenix Area
Bruce	Talawyma	IHS - Hopi Health Care Center
Lauren	Tancona	CDC – Phoenix
Wayne	Taylor, Jr.	Hopi Tribe
Floyd	Thompson	IHS - Gallup Medical Center
Shirley	Tila	San Carlos Apache Tribe 1
David	Toahty	Central Oklahoma Amer. Ind. Health Council
Rita	Todachine	Crownpoint Healthcare Facility
Lonnie	Tom	Confederated Tribes of Warm Springs
David	Toneman	Native American Community Health Ctr
Johnnita	Townsend	IHS - Albuquerque Area
Rosetta	Tracy	Indian Health Service 11
Jerald	Traversie	IHS – Aberdeen
Linda	Triest	Hannahville Tribal Council
Ron	Tso	IHS - Chinle Service Unit
Raymond	Tsumpti	Confederated Tribes of Warm Springs
Brenda	Turner	IHS - Phoenix Area
Gena	Tyner-Dawson	IHS - Rockville 1
Dr. W. Craig	Vanderwagon	IHS - Rockville 1
Marlene	Velarde	Jicarilla Behavioral Health
Alethea	Velasquez	White Mountain Apache
Donna	Vigil	White Mountain Apache
Tiffany	Vigil	Jicarilla Apache Nation
Chris	Walker	Cherokee Nation 2
Carl	Walking Eagle	Spirit Lake Sioux Tribe
Nelson	Wallulatum	Confederated Tribes of Warm Springs
Stella	Washines	Yakama Nation
Carroll	Webster	Omaha Tribe/Carl T. Curtis Health ED. CTR
Jessica	Webster	Omaha Tribe/Carl T. Curtis Health ED. CTR
Doreen	Welsh	Colorado River Indian Tribes 2
Kathleen	Wesley-Kitcheyan	San Carlos Apache Tribe 1
Carol	Wewa	Confederated Tribes of Warm Springs
Ada	White	Crow Tribe
Charles W.	White	Makah Tribal Council
Emmett	White Temple	Standing Rock Sioux Tribe 2
Dudley	Whitehorn	Osage Tribe of Indians
Eugenia	Whiteshirt	Pawnee Nation of Oklahoma
Lehta	Whitewolf	Northern Cheyenne Tribe 1
Cliff	Wiggins	IHS - Rockville 1
Doni	Wilder	IHS - Portland Area
Wanetah	Wilkins	CMS 9
John	Williams	Osage Tribe of Indians
Raymond	Willie	IHS - Albuquerque Area



Kathey	Willson-Ecoffey	IHS - Pine Ridge
Phyllis	Wolfe	IHS - Rockville 1
Fiona	Yazzie	Colorado River Indian Tribes 2
Peterson	Yazzie	Navajo Nation 2
Julia	Ysaquirre	State of Arizona
Julia	Ysaquirre	AHCCCS
Lorena	Zah-Bahe	IHS - Fort Defiance





Conference Sponsors





Conference Sponsors

**Department of Health and Human
Services**

Indian Health Service

**San Carlos Apache Tribe – Conference
Bag Sponsors**

Pascua Yaqui Tribe – Break Sponsors

ASCG – Final Report Sponsors

National Indian Health Board